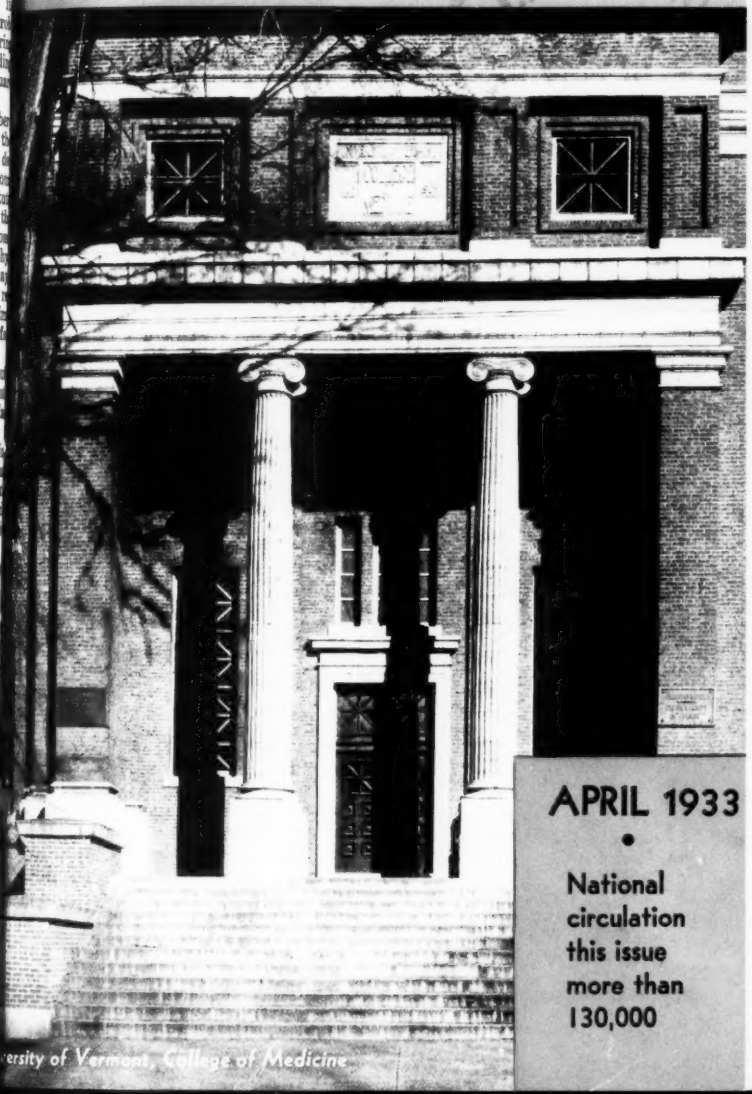
Medical Economics

The Business Magazine of the Medical Profession



APRIL 1933

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National circulation this issue more than 130,000

SPEAKING FRANKLY

Subscribes TO THE EDITOR: Permit me to subscribe to the opinion of Dr. Mussun, expressed in your Speaking Frankly section of January MEDICAL ECONOMICS, in which he suggests a national organization, founded on the principles of the Public Health League of California.

Personally, I have been averse to national organizations, because, after observing the workings of The National Organization for This or That, and noting practically the same set-up back of all of them (the underlying objective being socialized or state medicine), I am still of the opinion that public health practice should be limited to the health problems of the masses, and that personal health is a matter solely for the private practitioner.

I believe, further, that the solution of the mortality and morbidity rates in several diseases will be lowered not by the establishment of an elaborate and expensive array of clinical service, but by the advancement of medical science, made possible through the efforts of the private practitioner.

F. G. Metzger, M. D.
Carthage, N. Y.

Agrees TO THE EDITOR: I want to second the motion made by Dr. Mussun in January MEDICAL ECONOMICS. I believe that Dr. E. H. Crane's efforts in Los Angeles County, and the success the Physicians' Public Health League has achieved there, deserve a national trial on the lines pointed out. In that direction may lie the solution to some of the ills of our profession.

May I also express my entire agreement with Dr. Baketel's editorial in February MEDICAL ECONOMICS entitled "A Surgeon Writes an Exposé of Surgery." I am in accord with this for the same reason that I applauded the article, 'The Committee Reports,"—because in my opinion, we should avoid destructive publicity about the medical profession at a time like the present.

Edward S. Dougherty, M.D.
Ashley, Pa.

In accord TO THE EDITOR: I was encouraged to read the comments of Dr. William G. Mussun in your January issue relative to the Physicians' Public Health League. I am heartily in accord with his idea of making this economic organization nation-wide.

Fortunately or unfortunately, the present depression has forced an otherwise lethargic profession to realize that, since the dawn of history, the physician has been exploited by others who would quiet him with the bugbear of ethics.

Certainly, in face of the constant growing of other organizations, the medical profession will find itself subservient to politicians or worse, unless it unites for action.

J. M. Neil, M. D.
Oakland, California

Endorses TO THE EDITOR: In your January number of MEDICAL ECONOMICS (Speaking Frankly) Dr. William G. Mussun advocated that the Physicians' Public Health League of California be made a nation-wide organization.

Dr. E. H. Crane, secretary of the League, made the same suggestion in his article, "We Needed Action," in September MEDICAL ECONOMICS. He suggests that the project be known as the Public Health League of America. His idea is a good one, and I heartily endorse it.

J. R. Venning, M. D.
Fort Atkinson, Wisconsin

Pleased TO THE EDITOR: I wish to express my desire to see the Public Health League of California become a national organization and take pleasure in endorsing the letter of Dr. Mussun regarding this movement, published in your January issue of MEDICAL ECONOMICS.

J. E. Whitlow, M. D.
Fillmore, California

Valuable TO THE EDITOR: I heartily endorse Dr. Mussun's suggestion that a Public Health League of America be organized, as such an activity would be of great benefit to the profession as well as to the public. Your journal is doing a good work, and more power to you! You have some extremely valuable articles in MEDICAL ECONOMICS, and it is proving of great value to the profession.

S. C. Long, M. D.
Bakersfield, California

Contract TO THE EDITOR: I have read in MEDICAL ECONOMICS a good deal about the good and evil of contract medicine.

What is contract medicine and what will it consist of and how will it be managed?

If contract medicine is a good thing for the average man of the profession, I am for it. The average men of the profession are in the majority.

These average men may have some hidden ability that was overlooked or could be developed if they received a little financial stimulus and could get their minds off fear.

Charles Weishaar, M.D.
Aberdeen, S. D.

MEDICAL ECONOMICS
The Business Magazine of the Medical Profession

?? Contract Practice ??

IT'S TIME TO REMOVE THE QUESTION MARKS

By Harold S. Stevens

PHYSICIANS are wondering about contract practice.

They want to know:

1. What forms of contract practice, if any, organized medicine considers ethical.

2. What forms are unethical and how to eliminate them.

Generalizations are out of place. The medical profession wants to know definitely what is what.

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The judicial council of the American Medical Association has said this:

> By the term "contract practice" is meant the carrying out of an agreement between a physician or a group of physicians as principals or agents, and a corporation, organization, or individual, to furnish partial or full medical services to a group or class of individuals for a definite sum or for a fixed rate per capita.

That is a definition. It says nothing about ethics. Regarding that phase, a clause has long stood in the Principles of Medical Ethics of the American Medical Association (Article VI, Section 2) reading:

> CONTRACT PRACTICE
>
> It is unprofessional for a physician to dispose of his services under conditions that make it impossible to render adequate service to his patient or which interfere with reasonable competition among the physicians of a community. To do this is detrimental to the public and to the individual physician, and lowers the dignity of the profession.

This clause raises questions which it fails to answer, namely: Does contract practice necessarily "make it impossible to render adequate service"; and "does it interfere with reasonable competition."

Proponents of contract practice offer evidence that it does not necessarily do either. Those who oppose it, offer arguments to the contrary. Who are right?

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Consider, for example, contract practice in its very simplest form —an agreement between one physician and one patient, providing medical care in return for a regu-

lar monthly or annual fee. In practical application, this agreement would be expected to extend gradually among a whole clientele, so that the physician would serve fewer and fewer patients on the individual-call-and-fee basis.

The pediatrician who offers a "baby health service" at a yearly rate; the obstetrician who quotes an inclusive fee for pre-natal, confinement, and post-natal care; even the surgeon who tells the patient approximately what his operation and attending expenses will amount to—these three are certainly approaching contract practice, even though the contract is not in written form.

Are such forms of service unethical, provided the physician fulfills his duty sincerely and does not advertise for patients?

The American Medical Association, to whom most physicians look for official declarations of this sort, has yet to say whether they are ethical or not, and why.

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An opposite extreme of contract practice is the "health service" sold to the public by a commercial organization which employs medical men on a part or full time basis. The extent to which this arrangement can prostitute medical service is obvious.

Between these two extremes are intermediary steps:

1. An agreement between the patient and a hospital or private group clinic, or even a county medical society (example: the Bassett Hospital Guild, Cooperstown, N. Y.);

2. An agreement between a municipality or other governmental unit, and the physician, to give medical service to taxpayers on a salary basis (example: the municipal doctor system in Saskatchewan, Canada);

3. A similar agreement existing between an association and a physician, for the care of members (example: lodges);

4. A similar agreement between a company and a physician for the care of employees (example: railroads).

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It is wrong to assume that the great majority of physicians are unalterably opposed to contract practice. Today many thousands of capable doctors are sure that almost anything would be better than present conditions surrounding the private practice of medicine. Necessity has driven them into progressive lines of thinking.

Many of these physicians are conscientiously experimenting with the individual-doctor forms of contract practice mentioned a few paragraphs back. Many more have drifted into contracts with lay organizations whose obvious motive, sugar-coated with sweet talk about lowering the American people's sickness budget, is to milk a new racket. This is not universally the case, of course, but such motives are common enough.

No honest physician wants to prostitute his services. Lay control opens the way to such prostitution in its worst form, and divests doctor and patient of any guise of personal relationship.

The American Medical Association has done well to point out these and other dangers so repeatedly and emphatically. All sincere physicians know the warnings by heart and by instinct.

But physicians are beginning to sense the fact that all forms of contract practice are not of the same color. The American Medical Association has said that much. Dr. R. G. Leland, director of the A.M.A. Bureau of Medical Economics, told the Annual Congress on Medical Education last year that "Contract practice under certain conditions and in some forms is both ethical and legitimate. . .has some features that deserve refinement and extension and others that are un-

ethical and dangerous and should be abolished."

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Physicians are not helped particularly by such generalizations. Academic surveys of the good and bad features of contract practice are useful in debate. The physician who is faced with the daily, individual, grinding problem of earning a livelihood wants definite, constructive, positive guidance, not theories.

Could a start be made by stating definitely *what one form of contract practice meets the A. M. A. standard of ethics?* To do that would be a progressive step. It could easily be the A.M.A.'s noblest contribution of the year toward the economic advancement of medicine.

What about the simplest form of contract practice—the agreement, verbal or written, made directly between doctor and patient (see examples given previously in this article). Consider its points, in theory.

As applied between the ordinary practitioner and the ordinary patient, such an agreement has as its chief objection the fact that few physicians today possess the knowledge or equipment to give *complete* medical service. Hence, it would often be necessary to go elsewhere for laboratory work, X-rays, surgery, and hospitalization.

These minor objections can be raised: that the burden of serious, prolonged, or chronic illnesses among such a clientele would be too heavy for one physician to handle; that if consultations and other outside service were made at the doctor's expense, his decisions might be influenced to the patient's disadvantage; that the physician would be at the mercy of hypochondriacs (a difficulty which could probably be avoided by carefully selecting the patients).

The *advantages* for the physician are a more or less fixed income and a reduction of bookkeeping and collection detail. For the patient there is the incentive to give the physician closer supervision over health, thereby employing principles of preventive medicine to full advantage. Also of interest to the patient is the fact that the risk of heavy illness expense is lessened or eliminated.

Is the arrangement ethical?

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The A.M.A. Bureau of Medical Economics should take a practice of this kind, describe its operation, and flatly declare it ethical or non-ethical, with reasons. It should rule "approved" or "non-approved," as it has done with drugs, foods, apparatus.

That would establish a concrete precedent on which to proceed to the next step—and eventually to a complete policy in regard to contract practice.

One page of such precedent will be worth a volume of theoretical discussion, fumbling in the dark.

Will the A.M.A. lead its members toward the answer to this question? Or will it reluctantly be led by its more progressive component societies, its more progressive individual members?

Will lay racketeers prostitute medical service under the sign of "health insurance," while organized medicine is carefully painting theories?

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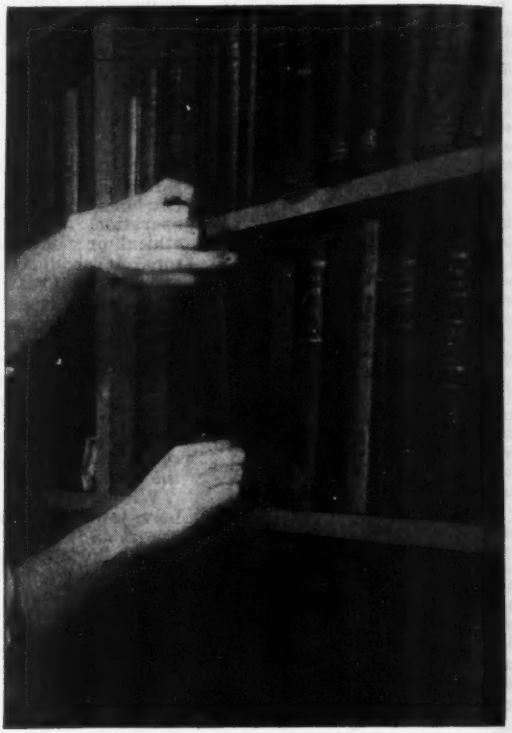
A new book, "How to Budget Health," by Evans Clark, director of the Twentieth Century Fund, discusses contract practice as applied in its various forms. This volume quotes extensively from MEDICAL ECONOMICS, *from the Committee on the Costs of Medical Care researches, and from other studies in the health field.*

The physician who wants to study contract practice intensively will find this book his most convenient source of material. The publisher is Harper & Brothers, 49 E. 33rd St., New York; the price, $4.

Why Don't Doctors Buy



Among thinking physicians, the fact is generally conceded that MORE medical men should read MORE medical books. Why don't they? Is the fault all theirs? Is there something wrong with the books, or with publishing methods?

Dr. Rowell is particularly well qualified to answer these questions. As a teacher of health education, he sees the matter from an unbiased viewpoint. He makes these specific criticisms: 1. that medical books are unnecessarily expensive; 2. that they are often too academic; 3. that most of them should be more clearly and concisely written.

More Medical Books?

By HUGH GRANT ROWELL, M.D.

Assistant Professor of Health Education
Teachers College, Columbia University

OVER in one corner of my library is a red covered book which has drawn innumerable caustic comments from physicians. Yet from it comes a statement almost as important as the Oath of Hippocrates.

Medical men, the book reads, *must consciously realize the obligations imposed by their calling, try to find time for study, to keep up with the times, and to make their practices accord with the latest sound findings of research.*

If this policy could be adopted universally in our profession, it would be the best possible refutation to the charge that medical men know more about medicine when they leave medical school than at any subsequent time, and that they make little or no attempt to keep up to date.

How may a doctor keep abreast of the latest and soundest in the healing art?

On my desk are numerous circulars of professional improvement courses. In the journals I find still others advertised. The cost varies from twenty-five dollars for a few evenings to vastly greater sums for invasion of the clinics of other continents. But most doctors answer these attractive invitations in the words or thought: "I can spare neither the time nor the money."

How, then, *shall* a doctor keep up?

First of all, perhaps, by attending professional meetings. But the accessible ones are comparatively few. In the main, doctors must keep stride with the times by their reading. You can, indeed, attend many of the outstanding medical meetings *in absentia,* merely by reading the papers afterwards in the current medical journals.

So be it. Reading shall be the means. We'll assume that time is available, since *any doctor can have time for reading if he willl take time.*

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"All right," said the physician with whom I was lunching the other day, "tell me how much money I should spend on my periodicals and books."

I hesitated to answer his question with definite figures. In fact, I realized that I could not do so, due to the wide discrepancy between the reading matter the doctor *should have,* and what he *can afford.*

I did, however, state my thoughts in general terms, expressing the further opinion that any doctor *should,* and probably *could,* follow about a dozen of the best medical journals, including some devoted to the specialties.

"But why a dozen journals," he asked.

"Simply because so many are published that the first-class material is widely scattered," I replied.

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It seems hardly necessary to illustrate the high cost of medical books. But, for completeness' sake, let's take a current issue of the Journal of the American Med-

ical Association and scan the book advertising for fundamental titles. This is what we find: obstetrics, $10; minor surgery, $10; pathology, $10; materia medica, $6.50; accidents, $10; clinical laboratory methods, $6.75; allergy, $5; total, almost $60, with no books on skin, laryngology, rhinology, otology, opthalmology, orthopedics, pediatrics, or other subjects.

And, let's see. How many home or office visits are required to bring in sixty dollars—visits with money *collected* (for we'll have to *pay* for the books)? Publishers, unlike physicians, do not maintain charity accounts on their ledgers.

Furthermore, sixty dollars is only a beginning. The physician is more likely to spend between two hundred and five hundred dollars for the latest in periodicals and books. And even after he has done so, a great deal of what he has accumulated may be stale within a twelvemonth. Perhaps that eminent scientist and jester, Dr. Elmer Southard, was right in advising his students never to buy a book if they could beg, borrow, or steal it.

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Taking a more serious view of the matter, the medical literature we purchase is an investment. As such we have a right to expect that it be offered at a sound price, that it be in keeping with our needs, and that it pay us dividends. All too many books offered to the physician fall down in one or more of these respects.

In the first place, their cost is usually excessive. Unless I am mistaken, cuts in selling prices will be the next step taken by the publishers of medical tomes. And rightly so! Leather covers have disappeared. Fine books are really for collectors, not for working doctors. Practical book building will have to succeed enthusiastic and expensive artistry, both in illustration and typography. I have yet to be convinced that the practical value of the volumes would suffer as a result.

For one thing, many of the halftones and lithographs with which medical books are replete could be replaced by line-cuts. These would be vastly clearer to the reader and infinitely less expensive, due to the reduced costs of cuts and paper. In a recent book of mine, the artist gave us, through line-cuts, all the detail that halftones could have conveyed, far more clearly and at a fraction of the cost.

Another reason why books are expensive lies in too-frequent attempts to make them museums of knowledge from sources other than the author's own experience. This is seldom really necessary.

Even though few authors seem to know how to build texts ably, there are several shining examples. Rosenau is one. His book, *Preventive Medicine and Hygiene*, is not only readable, but it is compressed into just as little space as is humanly possible. I thoroughly believe that many large and expensive medical texts could be cut exactly in half, and at the same time tell their story more clearly and usably.

Interesting enough, and in striking contrast to the above, is the fact that if the physician wishes to use these same books for research background (as I have had to do on many an occasion) he finds that they are too often inconclusive. In defeat of their apparent show of erudition, many are likely to take him up on Nebo's lonely mountain, allow him, like Moses, to view the Promised Land, and then leave him there stranded, or with only a vague suggestion as to how he may reach his goal.

How many texts on the eye, for example, give us any adequate idea about the theories of myopia or Snellen's fundamental studies? In contrast, read Cushing. What the master doesn't tell you on the page, he brings to you through an adequate bibliography.

Interesting (TURN TO PAGE 127)

What Publishers Say

IN REPLY TO DR. ROWELL

Comments by J. Norris Myers, managing director, Medical Department, The Macmillan Company:

CURIOUSLY, perhaps, my views on the subject of medical books are not altogether commercial.

Although a publisher today must sell books to be successful, his activities are, or should be, of a professional character. His position is akin to that of the physician in that it involves definitely ethical and cultural considerations.

The study of medicine is an intellectual pursuit. As such, it is dependent upon good literature. In this instance, "good literature" means good textbooks.

My own view of the matter is that in building a library for himself, the practicing physician should not rely entirely on any one book in a subject. It is well, of course, to select a "key book" on each branch of medicine; but this book should invariably be supplemented by additional texts — preferably the smaller, more concise, less expensive monographs that are published from time to time.

By doing this, and by perusing a carefully selected list of periodicals each month, the practitioner can keep himself fairly well abreast of developments in general medicine and in its component specialties.

Let me say with reference to Dr. Rowell's article in this issue that I fully concur with nine-tenths of what he has to say. Publishers *are* partly to blame for the current unsatisfactory situation with respect to medical books. But they are not *wholly* to blame. For book publishing has been affected by the social and economic "revolution" as has every other American activity.

We may recall that back in "the good old days" the publisher used to be the professional advisor and friend of the medical book author. A personal relationship existed at that time which is not so much in evidence today. Books then were few in number, but their scarcity was compensated for by their comprehensiveness. The majority of volumes were produced by leaders in the profession: men like Osler, MacKenzie, and Allbutt.

It was the life-long ambition of many a famous medical figure during this era to become the author of a masterpiece covering completely his particular field of research. Several of them succeeded. Their productions were, indeed, indescribably beautiful and comprehensive additions to the study of medicine. Publishers at the time sponsored this trend, knowing that the followers of such eminent medical leaders

would gladly pay the price to own copies of their complete writings.

But medicine has advanced since then. It has expanded far beyond its former bounds. No one physician could, or would now attempt to, discuss in its entirety a given branch of medical science. Instead, the man who wishes to write on medicine today selects a specialty—often an ultra-specialty. To this he can do justice with reasonable success.

But despite the underlying metamorphosis that has been going on in the last twenty-five years, despite the persistent trend in the direction of smaller, more specialized, up-to-date, and more reasonably priced medical books, a number of publishers continue in the old rut.

They cannot seem to realize that, with but a few exceptions, *the day of the big fifteen-or twenty-dollar medical tome has passed.* In discussing this tendency with the deans of our leading medical schools some time ago, I found them fully aware of it, unable to understand why the needed change in medical book publishing had not been grasped by the publishers themselves.

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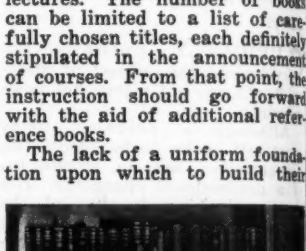
A frequent objection heard is that the market is glutted with medical texts of low quality. By quality, I mean quality of content. Marketing methods are largely to blame for this. Presses must be kept running by publishers who operate their own presses; sales forces must be kept busy; high-priced books must be published to enable salesmen to make sufficient commissions.

In the final analysis, there are two basic ways of merchandising medical books. The publisher can sell small quantities of a high-priced book; or, if he adheres to the more modern method, he will sell large quantities of a lower-priced book. The latter volumes are finding more and more favor with the physician who uses them. Their sales are growing markedly each year.

Now a few words regarding the chaotic condition in medical schools in so far as textbooks are concerned. Any number of able teachers have confirmed my belief that the student's instruction in medicine should be based largely on *required* texts—regardless of the high quality of classroom lectures. The number of books can be limited to a list of carefully chosen titles, each definitely stipulated in the announcement of courses. From that point, the instruction should go forward with the aid of additional reference books.

The lack of a uniform foundation upon which to build their



understanding of medicine explains some of the difficulties of so many medical students today. This situation is particularly unfortunate in that it is *not necessary.* It has been caused by the failure of medical schools to *require* certain textbooks.

How often an instructor will read off a list of books and declare them all more or less inadequate, giving the impression to the student that he can use "any old book"! The contempt for books thus created is often irreparable. Carried into practice, it is apt to do untold harm. Doctors *must* read books in order to keep up. [TURN TO PAGE 11]

250 Books

A SURVEY OF THE DOCTOR'S LIBRARY

is MEDICAL ECONOMICS' five-foot bookshelf. Actually, it comprises a whole series of bookshelves: one for the general practitioner, one for the specialist in each major branch of medicine.

What volumes should be given space in the doctor's library is, of course, a matter of widely varying opinion. Selecting a representative list of books for the physician is like selecting an All-American football team. Every authority has his own favorites.

In compiling the groups of books that follow, MEDICAL ECONOMICS was careful to include only those representing the composite choice of leading authorities. Here is the method by which this was done:

1. Three hundred and seventy senior professors in medical schools approved by the A. M. A. were asked to name the best books in their individual branches of medicine. A professor of gynecology, for example, was requested to state what books on gynecology should be in the library of (a) the gynecologist, (b) the general practitioner.

2. The seventeen foremost American medical book publishers were asked to enumerate—not the books they would recommend, but —their best sellers. Thus, the answers given were factual, rather than opinionative; and they indicated clearly the tastes of medical men today.

3. Each of the twenty-eight best known medical authors—every man a specialist in a different field—was asked to state what books in his specialty he would recommend for (a) the specialist, (b) the general practitioner.

4. A group of medical librarians were asked to check the lists of specialists' books and to suggest a well-rounded, beginning library for the general practitioner.

5. Finally, to confirm the views of these authorities, a number of practicing specialists and general practitioners were also queried.

The lists given below represent a thorough digest of opinions from these five sources.

The first list outlines a basic library for the general practitioner. The second gives a number of general books for both general practitioner and specialist. Subsequent lists indicate what books (listed in the order of their popularity) each different specialist should have. These suggested libraries may be kept up-to-date by purchasing such small, inexpensive monographs as are published every year, and by following the better periodicals.

The number appearing after each title denotes the publisher from which the book may be obtained (*see list of publishers on page* 21).

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A Library for the General Practitioner

Gray, *Anatomy*, 4; Gwathmey, *Anesthesia*, 12; Zinsser, *Bacteriology*, 12; Peters and Van Slyke, *Quantitative Clinical Chemistry*, 9; White, *Heart Disease*, 12; Andrews, *Diseases of the Skin*, 8; Norris & Landis, *Diseases of the Chest*, 10; Cabot, *Physical Diagnosis*, 9; Todd & Sanford, *Clinical Diagnosis*, 10; MacLester, *Nutrition and Diet*, 8;

Falta, *Endocrine Diseases*, 2; Rehfuss, *Diseases of the Stomach*, 8; Rosenau, *Preventive Medicine*, 1; Zinsser, *Resistance to Infectious Diseases*, 12; Osler, *Principles and Practice of Medicine*, 1; Cecil, *Textbook of Medicine*, 8; Sollman, *Pharmacology*, 8; Bastedo, *Materia Medica*, 10; Dorland, *American Illustrated Dictionary*, 10; Garrison, *Introduction to the History of Medicine*, 8; Webster, *Legal Medicine and Toxicology*, 8; White, *Outlines of Psychiatry*, 15; Jelliffe & White, *Diseases of the Nervous System*, 10; De Lee, *Principles and Practice of Obstetrics*, 8; May, *Diseases of the Eye*, 9; Jones & Lovett, *Orthopedic Surgery*, 9; Jackson & Coates, *The Nose, Throat and Ear*, 8; Boyd, *Pathology of Internal Disease*, 4; Holt & Howland, *Diseases of Infancy and Childhood*, 1; Stewart, *Physiotherapy*, 13; Starling, *Principles of Human Physiology*, 4; Mead, *Diseases of the Mouth*, 6; Da Costa, *Modern Surgery*, 8; Young & Davis, *Urology*, 8; Simmons & Fishbein, *Medical Writing*, 16.

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General Books

Lambert & Goodwin, *Medical Leaders*, 17; Da Costa, *Papers and Speeches*, 8; Stryker, *Courts and Doctors*, 12; Haggard, *Devils, Drugs, and Doctors*, 11; Percival, *Percival's Medical Ethics*, 9; Peabody, *Doctor and Patient*, 12; Cushing, *Life of Sir William Osler*, 10; Wyeth, *With Sabre and Scalpel*, 10; De Kruif, *Microbe Hunters*, 10; Harding, *Fads, Frauds, and Physicians*, 10; Melish-Wilson, *The Writing of Medical Papers*, 8; Stedman, *Practical Medical Dictionary*, 10; Seelig, *Medicine, an Historical Outline*, 9; Robinson, *The Story of Medicine*, 10.

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Libraries for Specialists

ANATOMY, EMBRYOLOGY, HISTOLOGY

Gray, *Anatomy*, 4; Bailey & Miller, *Embryology*, 9; Maximow, *Histology*, 8; Piersol, *Anatomy*, 5; Arey, *Developmental Anatomy*, 8; Bailey, *Histology*, 9; Cunningham, *Anatomy*, 9.

ANESTHESIA

Gwathmey, *Anesthesia*, 12; Flagg, *Art of Anesthesia*, 10; Labat, *Regional Anesthesia*, 8; Evans, *Spinal Anesthesia*, 13; Hedfield, *Practical Anesthetics*, 9; Hewitt, *Anesthetics*, 7.

BACTERIOLOGY

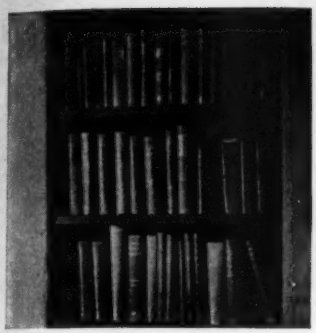
Zinsser, *Bacteriology*, 12; Topley & Wilson, *Principles of Bacteriology and Immunity*, 9; Park, Williams, & Krumwiede, *Pathogenic Microorganisms*, 4; Jordan & Falk, *Bacteriology and Immunology*, 14; Ford, *Bacteriology*, 8; Kolle, Kraus, & Uhlenhuth, *Handbuch der Pathogenen Mikroorganismen*, 10.

CHEMISTRY

Peters & Van Slyke, *Quantitative Clinical Chemistry*, 9; Hawk & Bergheim, *Practical Physiological Chemistry*, 2; Mathews, *Physiological Chemistry*, 9; Bodansky, *Physiological Chemistry*, 10; Cameron, *Biochemistry*, 12; Gorton, *Biochemistry*, 10.

CHEST, HEART, AND LUNGS

White, *Heart Disease*, 12; Lewis, *Diseases of the Heart*, 12; Norris



PUBLISHERS

[Numbers following book titles refer to publishers listed below.]

1. D. Appleton & Co., 35 West 32nd St., New York.
2. P. Blakiston's Son & Co., Inc., 1012 Walnut St., Philadelphia.
3. F. A. Davis Co., 1914 Cherry St., Philadelphia.
4. Lea & Febiger, 6th & Locust, Philadelphia.
5. J. B. Lippincott Co., 227 S. 6th St., Philadelphia.
6. C. V. Mosby Co., 3523 Pine Blvd., St. Louis, Mo.
7. Oxford University Press, 114 Fifth Ave., New York.
8. W. B. Saunders Co., W. Washington Square, Philadelphia.
9. The William & Wilkins Co., Baltimore, Md.
10. Chicago Medical Book Co., 435 S. Honore St., Chicago.
11. Harper and Bros., 49 E. 33rd St., New York.
12. The Macmillan Co., 60 Fifth Ave., New York.
13. Paul B. Hoeber, Inc., 76 Fifth Ave., New York.
14. University of Chicago Press, Chicago.
15. Nervous and Mental Disease Publishing Co., Washington, D. C.
16. American Medical Association, 535 North Dearborn St., Chicago.
17. Bobbs-Merrill Co., 185 Madison Ave., New York.
18. Houghton, Mifflin Co., New York.

& Landis, *Diseases of the Chest*, 10; Fishberg, *Pulmonary Tuberculosis*, 10; Myers, *Normal Chest of the Adult and Child*, 9; Livingston, *Tuberculosis*, 12; Myers, *Modern Aspects of Tuberculosis*, 9; Cabot, *Facts on the Heart*, 10; Lewis, *The Heart Beat*, 10.

DERMATOLOGY AND SYPHILOLOGY

Andrews, *Diseases of the Skin*, 9; Sutton, *Diseases of the Skin*, 6; Macleod, *Diseases of the Skin*, 10; Stokes, *Modern Clinical Syphilology*, 8; Ormsby, *Diseases of the Skin*, 10; Sequeira, *Diseases of the Skin*, 12; White, *Occupational Affections of the Skin*, 10; Pusey, *Dermatology*, 1.

DIAGNOSIS

Cabot, *Physical Diagnosis*, 9; Todd & Sanford, *Clinical Diagnosis by Laboratory Methods*, 10; Barton & Yater, *Symptom Diagnosis*, 1; Fisk & Crawford, *The Periodic Health Examination*, 12; Blumer, *Bedside Diagnosis*, 8.

DIETETICS AND NUTRITION

McCollum & Simmonds, *Newer Knowledge of Nutrition*, 12; MacLester, *Nutrition and Diet in Health and Disease*, 8; Lusk, *Science of Nutrition*, 8; Sherman, *Chemistry of Food and Nutrition*, 12; Alvarez, *Mechanics of the Digestive Tract, Nervous Indigestion*, 13; Rose, *Feeding the Family*, 12; Gauss, *Clinical Dietetics*, 6; Sansum, *Normal Diet*, 6.

ENDOCRINOLOGY

Falta, *Endocrine Diseases*, 2; Harrower, *Practical Endocrinology*, 10; Curschmann, *Endocrine Disorders*, 10; Allen, *Sex and Internal Secretions*, 10; Mazer, *Clinical Endocrinology*, 10; Engelbach, *Endocrine Medicine*, 10; Frank, *The Female Sex Hormone*.

GASTROENTEROLOGY

Rehfuss, *Diagnosis and Treatment of Diseases of the Stomach*, 8; Einhorn, [TURN TO PAGE 115]

Earthquake

SOME MEDICAL ASPECTS OF THE CALIFORNIA DISASTER

By Edwin F. Patton, M. D.

LATE afternoon on one of Southern California's typical Chamber of Commerce days. . . The homeward rush is just past its height. Many people have reached their dwellings already; a goodly number are in street-cars, buses, and automobiles, on their way to dinner; the rest are closing shop.

Suddenly the lights flicker and dim. A pecular rushing roar is heard. Then, like playthings on a table-top, shaken by an angry child, everything begins to sway, rock, creak. Loose things fall. Instantly the thought flashes: *Earthquake!*

•

Authorities state that the best thing to do is to stay where you are, moving only enough to keep out of range of anything which can be shaken loose from above. Many quiet souls do just this. Others rush wildly about, picking up children or objects, dashing for the outdoors. Some scream. Some jump from second and third story windows. Scores rush out hysterically from places of protection into the street, just in time to be pinned by falling walls, or struck by bricks, glass, ornamental stone or plaster, or loosely attached pieces of architecture.

In less time than it takes to tell, it is over. All that remains is to appraise the damage and to pick up the pieces.

There are succeeding shocks—many of them—but all less violent and less frequent. They continue decreasingly for a month. They are still going on as this is written, ten days after the original quake. Soon everybody gets used to them, and they are not alarming.

•

The Long Beach-Los Angeles earthquake struck at 5:45 P. M., March 10, bringing death to approximately 120, and injury to 1,500. By 10:30 P. M. the same evening, all casualties had received emergency care and had been transferred to homes and hospitals for follow-up.

An area of about 150 square miles was involved, centering around Long Beach. In Los Angeles, the usual channels, including the city emergency hospitals, under Dr. Wallace Dodge, were pretty well cleared in time for the doctors to have gone to the second show at the movies—had they felt like it. In Long Beach, where the problem was most acute, salvage work was organized and [TURN TO PAGE 107]

(Top illustration) A wrecked wing of the Seaside Hospital at Long Beach. Here, while walls crumbled and water mains burst, a baby was delivered.

(Center) A sailor, an ex-service man, and a civilian provide quick stretcher aid for a quake victim.

(Bottom) An emergency hospital set up in Lincoln Park, Long Beach.

The Children's Clinic

(PART TWO) THE TRANSFORMATION

By Frank Howard Richardson, M.D.

THIS business of making the doctor's office attractive is one that has been discussed frequently in MEDICAL ECONOMICS.

It may seem less vital in these troublous times than it was in the days when we thought more about luxuries and less about the essentials of living. Yet there is another way to look at this question.

"How shall I have an attractive office?" is, after all, but another way of saying: "How can I make my patients comfortable and contented enough to wait until I get around to attending them?" For that is just what it amounts to, especially when the waiting person is the mother of a restless child—than which there is nothing *more* restless.

Looked at from this angle, an attractive, restful waiting room is no longer a luxury nor the gratification of a harmless personal whim. It is plain medical economics!

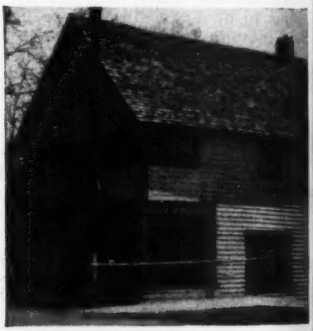
•

More than any of his colleagues, the pediatrician stands in need of provisions to keep his waiting patients contented. His patrons, if not his patients, are chiefly women who know something about how a house should be kept. And they do not hesitate to voice their opinions about such things.

With an armful or handful of trouble (and is there anything more worthy of the name than a wriggling baby or a restless youngster?) it is no wonder that such a woman appreciates finding in the doctor's office a means of occupying the attention of her infant charge.

The truth of this came to me with peculiar force one rainy afternoon when I tried by dint of every art I possess to prevent a mercurial five-year-old of my own from tearing apart the waiting room of a pediatric colleague to whom I was taking him for examination.

Why it was that the dog-eared, six-months-old magazines on the table did not interest him, I cannot say. Why he should not have been lulled into calm repose by the picture of the old bewhiskered doctor watching at the bedside of a dying child, I don't know.



The author found himself owner of this unpromising structure, which he set out to convert into a pediatric clinic. Contrast this picture with the drawing opposite.

Here is a sketch of The Children's Clinic, made after Dr. Richardson had talked with a landscape gardener. Notice the transformation. The article describes how expense was kept at a minimum.

One solitary toy would have made the wait endurable. But that was lacking.

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In addition to pleasant surroundings and something to absorb youthful energies, the pediatrician's waiting room should possess space—lots of it. For while patients go singly to other specialists, they practically never go unattended to a pediatrician.

There is always one parent at least—sometimes two. Not infrequently, an aunt, grandmother, nurse, or one or two other children go along also. If these folks have elbow room as well as occupation for the children, well and good. But if either is lacking, the length of time the most patient of the group is willing to wait will be short, indeed.

An orthopedic friend of mine in Brooklyn—a bachelor who uses almost his entire three-story dwelling for an office—boasts eleven separate rooms or alcoves in which he can bestow waiting patients while he goes leisurely from one to the other!

Another confrère, a pediatrician, employs five tables to which he assigns his patients in rotation. Instructions are given that they shall be undressed at once behind the screen that shuts off observation. Then the mother *has* to wait until he comes to her!

•

My "office building"—when I finally became possessed of one in which to carry on my summer pediatric practice—was a little square frame building, scarcely more than a packing box, in the mountains of North Carolina; it had been hastily thrown together by some jerry builder to serve as a combined store and dwelling.

There it sprawled, ten feet over the building line, encroaching

upon what would some day be the sidewalk. Its street-level front porch formed an arcade like those of old Chester in "Merrie England."

The lot on which it stood was 50 feet wide by 200 feet deep, much of it well below the level of the highway which had been built on a fill at this point. As "an attractive office," it seemed a hopeless misnomer at first—especially since I had spent all I could afford on acquiring the property, and so had no money to spend for remodelling or rebuilding.

Bearing in mind my beliefs regarding the requirements of acceptable pediatric waiting quarters, what was to be done?

I needed all the street-level floor for examining and consulting rooms, laboratory, toilet, etc. True, there was one fairly good sized room on the floor below this that might be used as a waiting room. But because the lot sloped rapidly from front to back, this room was distinctly beneath the level of the street.

•

The solution of the difficulty seems obvious by a glance at the grounds plan. But it was not so simple at the time.

When I began, it was not possible—nor could I have afforded it if it had been—to build an addition to a frame building situated within the fire limits of the town. It *was* possible, however, to let the children play outdoors, provided some part of the lot was made attractive enough to induce them to play there, instead of dragging at their mothers' skirts in the waiting room.

Remember, this was a summer situation that had to be met. Only during the summer would there be a sufficient volume of child-patients to necessitate making room for a number of them at the same time.

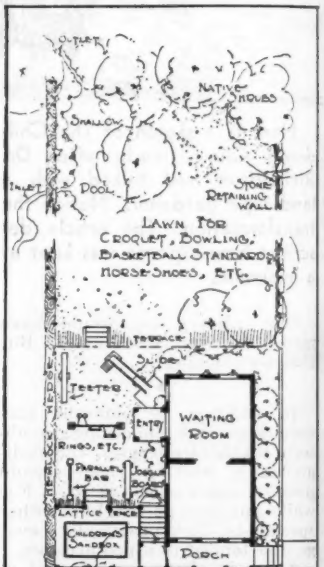
•

As I was still watching the pennies pretty carefully, the play equipment I installed was neither elaborate nor expensive.

From one of the mail order houses I purchased for three or four dollars a play set consisting of a trapeze bar, a pair of flying rings, and a swing seat, all designed to be used in rotation on one pair of ropes. These constituted the backbone of my playground.

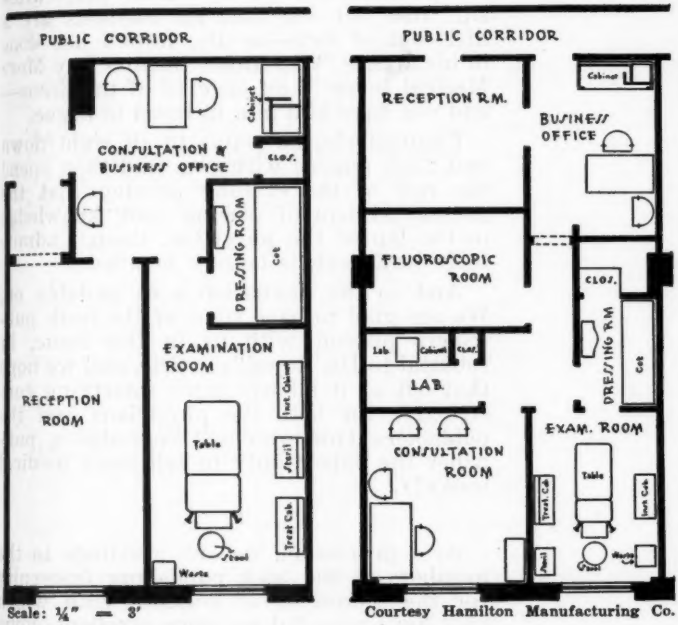
Next, I bought enough clothesline to make two more sets of ropes. These and the original set I suspended from three pairs of large screw-eyes inserted in a horizontal pole some ten feet from the ground. This gave me play equipment for three children at once.

(TURN TO PAGE 91)



(Above) A plan showing how the grounds are laid out. Generous playground facilities explain this pediatrician's local popularity.

Two Offices for the General Practitioner



Scale: ¼" = 3'

Courtesy Hamilton Manufacturing Co.

Because they know that dignity, convenience, and efficiency are the three necessary qualities of the modern medical office, doctors today are spending more attention than ever on the layout—soliciting the expert advice of the architect, surgical dealer, or equipment manufacturer. Care thus spent in the beginning pays dividends through all the coming years of practice.

Here are plans of two offices that were designed for general practitioners. The quarters are in a professional building, the floor area being approximately the same shape in both instances.

The first plan is the simpler, providing three main rooms and a cubicle for the patient to use when preparing for examination. Patients are able to leave the consultation room without passing through the reception room. One combined receptionist-secretary-nurse assists in this office.

The second layout is more elaborate. Both a receptionist-secretary and a nurse are required here. Two patients at a time can be handled without interference, as the consultation room and the examining room with the dressing cubicle are private from each other.

Medical Minds

WELL, the debate is on. Medical book publishers are pretty human chaps after all. Just tell one that his methods are a little out of date—as Dr. Rowell has done in his article "Why Don't Doctors Buy More Medical Books?" on page 12 of this issue—and you have him in a fit mood to argue.

Figuratively, he wants to sit right down and clink glasses with you, and then spend the rest of the evening proving that the present system of placing book knowledge in the lap of the physician, though admittedly inefficient, is largely justified.

And so the discussion goes amiably on. We are glad to have some of the book publishers present with us in this issue, in rebuttal to Dr. Rowell's article, and we hope that out of it all will come something constructive for both the physicians and the publishers (for who will begrudge a publisher the opportunity to sell more medical books?).

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As a profession, we owe gratitude to the members of the book publishing fraternity for the thousands of volumes with which they have provided us, some excellent, some mediocre. After all, their business is to sell books, as well as to educate us. If they make a poor guess on a new work, and lose money, that loss is in a sense a definite monetary contribution to medicine. If the guess is favorable, the resulting profits are deservedly theirs. In no branch of publishing can there be a scientific prognosis as to sales.

That much is granted. But Dr. Rowell, voicing a thought in the minds of many medical men, wonders to what extent the medical book publishers are handicapping themselves and their physician-customers with *old habits*. It is a human tendency to

Crave Their Food

make habits justify methods. Perhaps the publishers, in their replies to Dr. Rowell, are just being human. Perhaps they are just humanly loath to experiment with the things that Dr. Rowell suggests: cheaper, more concise, more understandable medical volumes, produced in larger quantities, making it possible for the doctor to have an adequate library at a fraction of the present cost. I do not pretend to know the answer. I am merely raising the point.

•

I do recall, however, a talk I had recently with the author of a medical work, as yet unpublished. This physician had taken his manuscript to an experienced medical book publisher, who predicted that 1,000 copies could be sold at $10 each, and was willing to assume the risk. But the author had different ideas. He was not interested in profits, but in the wide dissemination of the text. So he looked for a publisher who would print more copies and sell them cheaper. One printer he talked with figured carefully, and decided that 10,000 copies of the book could be produced to sell, including a reasonable profit, at a price of $3. The doctor is now carrying out a quiet investigation in an effort to determine whether enough physicians would buy his book at the lower price to justify printing 10,000 copies. The incident proves nothing, yet illustrates the fact that medical books *can* be sold more cheaply if printed in larger numbers.

To which our publisher friends will reply, a trifle bookishly:

> Books cannot always please, however good;
> Minds are not ever craving for their food.

H. Sheridan Baketel

Do You Photograph

By CARL D. CLARKE

Director, Dept. of Art and Photography
Medical School, University of Maryland

Several practical uses for case records in photographic form suggest themselves to the physician: 1. to illustrate medical papers, 2. to make lantern slides for the accompaniment of lectures, 3. to aid in explaining prognosis to patients.

Equipment of the right sort is essential if good results are to be secured conveniently. Mr. Clarke, while editor of the Journal of the Biological Photographic Association, has made thousands of medical photographs. Here, he tells how to select the proper apparatus.

This pertinent question is often asked by physicians and other workers in the biological sciences: "What kind of camera must I buy to do medical or biological photography?"

It is my belief that the average practicing physician does not intend to make a hobby of photography, nor does he intend to go into the subject in lengthy detail. On the contrary, he wants to have available equipment to use for a definite purpose, as he would use his ophthalmoscope or his blood pressure apparatus.

He cares little about the theory or physics of photography. Instead, he wishes to know something of its practical application. He is interested chiefly in having a photographic record of some of his interesting cases, possibly to file among his case histories. For he realizes the value of being able to show "before and after" photographs to his patients and colleagues.

Perhaps the opportunity will present itself to have lantern slides made from his best negatives for reporting at medical gatherings. Some of his cases may even find their way into medical literature.

At all events, the physician wants his photographic equipment to be good. He insists that it be reasonably priced. And he no doubt wants it to be versatile enough so that he may make personal use of it,—to photograph his family, to take on vacation trips.

There are cameras that meet these demands. Suppose we consider the purchase of one.

In the first place, the equipment is to be used primarily for clinical and pathological photography. Hence it should consist of:

1 Camera: double-extension bellows and ground-glass back essential;

1 Lens: preferably of good make and comparatively rapid;

1 Tripod: must be steady;

1 Suitable lighting unit: this can be of many varieties, although a single reflector with a 500-watt projection bulb or photoflood light will probably be found most convenient. Photoflash bulbs are handy and helpful in obtaining good pictures, but are more expensive where a great deal of work is to be done.

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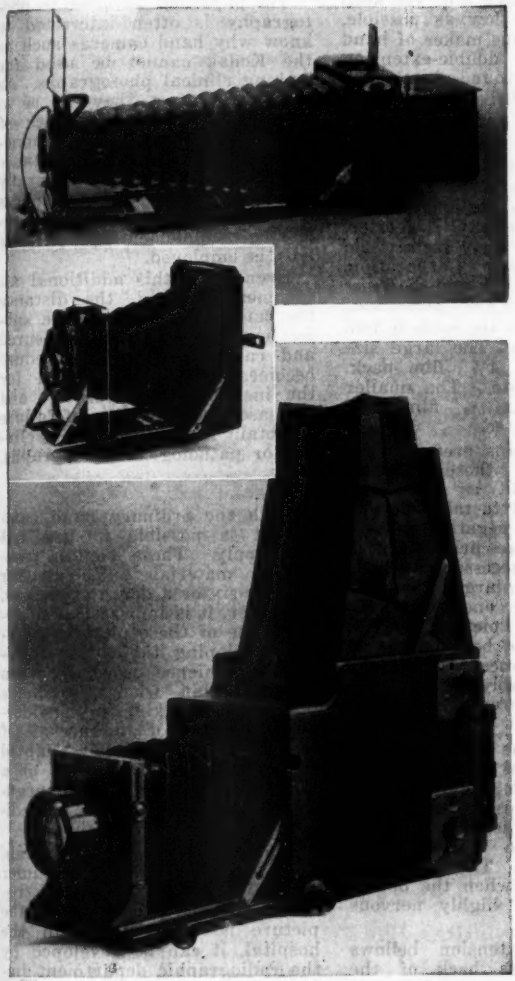
Your Unusual Cases?



Typical cameras used for medical photography. (Top) Zeiss MAXIMAR, (Center) KAWEE, (Bottom) Scientific GRAFLEX.

Now let us consider separately each piece of necessary equipment, beginning with the camera. For the practicing physician who desires to put his equipment to many diverse uses and yet keep the expense as low as possible, one of the various makes of hand cameras with double-extension bellows and ground-glass back probably will be most suitable.

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Among these are the *Kawee*, sold by Burleigh Brooks, 127 West 42nd Street, New York; the *Kodak Recomar*, sold by Eastman Kodak Company, Rochester, New York; the Agfa Isolar, sold by Agfa Ansco Corporation, Binghamton, N. Y.; and the *Zeiss Maximar*, sold by Carl Zeiss, Inc.,

These cameras are made in two convenient sizes. The large size takes a 3¼" x 4¼" film pack, cut films, or plates. The smaller size takes 2¼" x 3¼" film pack, cut films, or plates.

Many physicians prefer larger negatives than these cameras produce, but it is considered more economical to take the picture on a small negative and enlarge to the size print desired. It will not be necessary to have every picture enlarged, as only the outstanding ones merit it. Even the small picture, 2¼" x 3¼" in size, can be complete in detail and brilliance, provided the subject is suitably lighted and the negative properly exposed and developed.

These cameras under discussion have lenses with a speed of F:4.5, which facilitates the taking of pictures under adverse lighting conditions, and makes it possible to use comparatively short exposures. The latter become necessary when the operator works with highly nervous adult patients.

The double-extension bellows and ground-glass back of the camera allow accurate focus of objects photographed at close range. Examples of subjects that lend themselves readily to close-up photography are eye conditions (such as cataracts) and epitheliomas of the nose and other parts of the face.

The physician unversed in photography is often interested to know why hand cameras such as the Kodak cannot be used for making clinical photographs. As a matter of fact, they can be so used. But due to their lack of double-extension bellows, ground-glass back, and suitable distance scale, subjects cannot generally be taken with these cameras closer than about six feet, unless a supplementary portrait lens is employed.

Even when this additional attachment is used, the distance the camera is set from the subject must be accurately measured and calculated. This procedure becomes somewhat involved for the inexperienced operator, and increases the possibility of failure to obtain really worthwhile clinical or pathological photographs.

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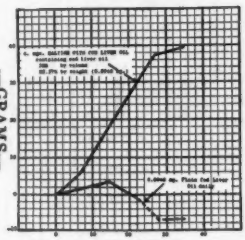
With the ordinary hand camera it is possible to use roll films only. These contain sensitized material sufficient for making six or a dozen exposures. Moreover, it is impractical to develop one of these pictures without developing the entire roll—an inconvenience, especially when the physician wishes to make tests before taking a considerable number of pictures. Of course, if the camera is adapted for using cut films, plates or a film pack, the individual negatives may be developed immediately after exposure.

It is often necessary to obtain a photograph of a surface tumor during the last few minutes before a surgical procedure. If the picture is to be taken in the hospital, it can be developed by the radiographic department immediately after exposure. The short time consumed in determining the quality of the negative

ENHANCING THE VITAMIN A *VALUE OF COD LIVER OIL*

THE medical profession has long used and recommended cod liver oil because of its therapeutic value in diseases and ailments of various types. More than 50 years ago, The Maltine Company, realizing the nutritive value of cod liver oil, studied the possibility of incorporating this oil in a concentrated malt extract, hoping thereby to increase the palatability of the oil and to make available to the medical profession an emulsion which would combine the virtues of the two components—MALTINE WITH COD LIVER OIL was the result.



The actual amount of cod liver oil received by the animals represented in the two curves was identical. Janes, E. R., Grover, H. F., and Quinn, E. J. "A Method of Enhancing the Vitamin A Value of Cod Liver Oil", Proc. Soc. for Exper. Biol. and Med., January, 1933, *p.* 516.

It was found that the new MALTINE WITH COD LIVER OIL was palatable and easily tolerated by children and adults, many of whom had previously found it difficult to take plain cod liver oil. More recently, tests of various kinds, including biological, and clinical, have shown that MALTINE WITH COD LIVER OIL has other characteristics, besides palatability, to recommend it.

One of the most recent findings is that an actual enhancement of the value of the cod liver oil occurs in the MALTINE WITH COD LIVER OIL emulsion. This finding is of so much importance, both from the practical as well as the scientific standpoint, that we quote from the article which appeared in the January issue of the Proceedings of the Society for Experimental Biology and Medicine, reporting work done in the research laboratories of the Maltine Company.

"The animals fed 0.8948 *mg. of cod liver oil daily in the form of the cod liver oil-malt extract emulsion* made an average gain in weight of* 39.7 *gm. during the* 5 *weeks' experimental period. Further, when xerophthalmia existed in the animals of this group at the beginning of the test period, the eye condition became decidedly improved or was entirely cured."*

In striking contrast were those animals fed plain cod liver oil and receiving the same amount of oil as occurred in the emulsion dosage. In this group xerophthalmia became more severe and many of the animals died with characteristic symptoms of Vitamin A deficiency before the end of the experimental period. This would indicate that the value of cod liver oil is enhanced when fed in the form of Maltine with Cod Liver Oil.

A chart, here illustrated, shows the average growth curves of test animals in the two groups.

MALTINE WITH COD LIVER OIL is biologically standardized and is guaranteed to contain a generous balance of vitamins A, B, D and G. Biological and vitamin report on request. THE MALTINE COMPANY, Est. 1875, 30 Vesey Street, New York, N. Y.

*(Maltine with Cod Liver Oil)

THE ORIGINAL

Maltine

WITH COD LIVER OIL

AMERICAN MEDICAL ASSN

Introduced in 1875

La maternidad en el siglo XVI

A SIXTEENTH century lying-in room showing the newly born infant being washed by the attendant midwife. At this period physicians were not allowed to attend at child birth. The delivery and the after-care of the mother were left entirely to untrained female servants. It was not until the 17th century that male doctors were allowed to deliver children.

will not hold up the surgeon to any great extent. If it is found to be poorly focused, exposed, or lighted, a second picture can be made, thereby insuring a permanent record of the case as it was before the part was surgically removed.

It is a common practice for physicians who have access to X-ray processing equipment to use it for developing their clinical photographs. This is perfectly permissible as far as the developer is concerned, for it has no harmful effects upon the processing solutions or the negative. However, it should be borne in mind that most X-ray developers give a contrasty negative which is not always desirable. In most clinical and pathological cases a slightly contrasty negative, of course, makes little difference, and can generally be corrected in the printing of the positive.

Now let us consider the tripod for the camera equipment described. A main requisite is that such a tripod be rigid and convenient to use. The author does not recommend the small collapsible type in which one pipe-like leg telescopes into another. A tripod for clinical work should have, if possible, a pam-and-tilt arrangement, similar to those used in amateur movie making. Such a tripod can be purchased with the pam-and-tilt for about fifteen dollars, or for ten dollars or less without it. In the long run, the additional expense will be well worth while.

For lighting equipment, a single reflector and bulb will be all that is necessary. Most photographic supply houses sell a reflector, bulb socket, handle, and ample electrical cord for a dollar and a quarter. This lighting unit will accommodate either a 500-watt projection bulb or a photoflood lamp. Photoflash bulbs can also be used in such a holder.

The lighting unit is designed to be held in the hand by the operator or by a second person while the exposure is being made. But if this proves inconvenient, one may obtain for an additional price of about five dollars a small metal stand or tripod which holds the light while arrangements for taking the picture are being made. Usually, such a stand is recommended.

Now a few words as to the differences among the various bulbs used in the reflector unit. A 500-watt projection bulb gives sufficient light to make pictures of clinical cases, using only a one-fifth second exposure with the diaphragm opening of the lens set at F: 5.6 or F: 6.3. Such a bulb, which costs about three dollars, will last for years if it is carefully used.

The 500-watt bulb, however, has been superseded among many physicians by the photoflood light which gives the equivalent of about 750-watts of light and costs only thirty-five cents. The photoflood light will burn for only about two hours; but even at that it is perhaps the most economical of all bulbs.

The next light to be considered is the photoflash bulb. It is a bulb for giving a single flash, and can be used only once. This method of lighting the subject is one of the best, but the expense is prohibitive in many cases. Photoflash bulbs are twenty-five cents each. Discounts are given when greater quantities are purchased.

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So far this discussion has been limited to one type of camera, for the reason stated before: because the physician wishes to use his camera for more than just taking clinical and pathological pictures, and because this type is a convenient pocket size, and costs less than many of the larger cameras. The complete equipment retails for about fifty dollars.

If the ex- (TURN TO PAGE 127)

Everybody's Business

By FLOYD W. PARSONS

THE present is rather a time for hope and satisfaction than for despair. The crash came and the worst is over. It has been evident for months that nothing less than a real crisis would start constructive forces and put an end to useless dallying with vital problems.

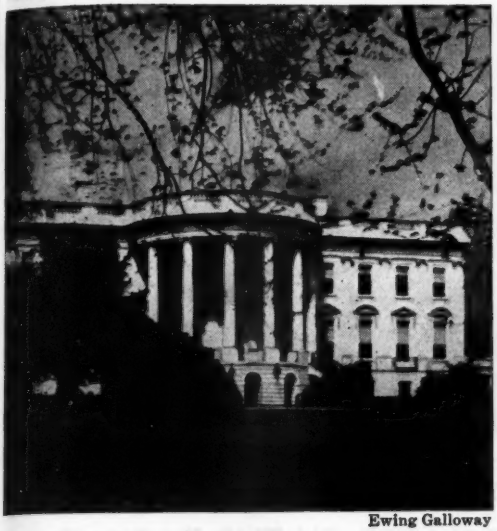
Sound-thinking people are not alarmed and have no fears of a permanent breakdown. They recognize plainly that the road to recovery has been cleared; that live assets will be separated from dead resources, permitting us to readjust ourselves to current realities; that efforts to keep alive insolvent banks and businesses by artificial means will be largely abandoned; that the country has discovered the futility of trying to borrow itself out of debt; and that over-extended credit will be gradually liquidated.

We may now look ahead with assurance to the reorganization or absorption of unsound business; to drastic economies in government resulting in the restoration of Federal credit; and to a regrouping of the nation's banks into a single powerful system supervised by the Federal Reserve. It is not more money we need, but sounder money; and the carrying out of these measures will revive confidence and start the upturn.

Major evils long hidden and foolishly glossed over are now dragged into the open. Out of chaos will come confidence and a rebirth of enterprise. It is safe to say that those who hoarded gold and currency will reap no greater reward than did the people who engaged in a mad scramble for stocks in 1929. Chances favor the probability that money a few months hence will be the least desirable asset to possess from a speculative viewpoint. Wise investors have read a significant forecast of ultimate recovery in the steadiness of the stock market in the face of panicky selling.

The widespread talk of inflation and the agitation for "elastic money" are merely omens that the depression is in its final stage. A study of previous periods of hard times discloses that the second year brings hysteria, the third develops disappointments over the failure of conditions to improve, and the fourth ushers in all sorts of suggestions concerning short cuts to revival through tinkering with the currency.

President Roosevelt has sensed the feeling of the



Ewing Galloway

AFTER THE CRISIS—WHAT?

"If the new President of the United States possesses the qualities here set forth, our people will follow his banner, right or wrong; and we will win out."

nation and intends to shape his actions accordingly. No chief executive ever went into office with more unanimous support, and doubtless he has recognized that if his courage is great enough, if he substitutes actions for words, the public will rise up and sweep aside any petty opposition that attempts to resume the dilatory policies of the past two years.

Our Presidents pay dearly for the privilege of serving the nation. Usually we send them back to private life beaten and crushed. Mr. Hoover left Washington a humbled, disappointed, heartbroken man. Theodore Roosevelt after a great performance in patriotic leadership was cast aside by a thoughtless, thankless people, and widely discredited by many who a short time before were his ardent supporters. Wilson was accorded the highest of honors by European nations, and twenty-six months later drove away from the White House a physical wreck—merely another President defeated by the duties of his high office and the ingratitude of those he faithfully served. We who carry on in little jobs of small importance may be truly thankful we have not been marked out for the cruel labors of a distinguished public position that depends on the whims of a fickle people.

Roosevelt has an unequalled opportunity to become a great figure in world history. He takes over the leadership of a nation stricken by economic ills, but one that has all its resources intact, its property undamaged, its public health at a record high level, and its natural and artificial productive agencies uninjured. He takes hold at a time when the life blood of the nation for years to come has been rendered immune

AN ANTI-RHEUMATIC APPRECIATED BY THE PATIENT

Fourteen clinical reports published in the past 5 years have shown that in a large percentage of cases of arthritic, rheumatoid and neuritic conditions the relief of pain, reduction of swelling and joint stiffness was prompt following the use of FARASTAN.

In arthritis and associated affections FARASTAN has been successful in the hands of many physicians because FARASTAN contains iodine and cinchophen in a single chemical formula, which is both dependable and effective.

If you have never used FARASTAN, let us send you a full sized package and a digest of the published work.

The Laboratories of THE FARASTAN CO.
137 South 11th Street Philadelphia, Penna.

to a return of the same identical ills that have brought us suffering and disappointment. He goes into office when the housecleaning has been practically completed and all that remains is to put across a few vital measures necessary to the restoration of confidence. His primary task is to see that the interests of selfish minorities are subordinated to the welfare of the wide public.

It is far better to venture out of the door and see what can be done than to remain inside the house and let it fall upon us. The time has come to quit turning away from international and domestic responsibilities; to prove to the world that we are something more than merely boast and bluster; to demonstrate that our courage is the kind that stands forth most plainly when things go wrong; and to show that we have decided at last to get out of the mud and slime of lawlessness, greed and rotten politics. No nation can rise above the level of its people, and no corrupt leadership can shoulder the United States with dishonor if our men and women individually show a proper sense of self-respect and pride of citizenship.

Centralized authority, group control, expert management and rigid discipline have come to be regarded as vital necessities. We have paid so dearly for our adherence to "rugged individualism" and unrestricted personal freedom that a mild form of dictatorship is more than welcome. We want permanent alterations in our national set-up, and we believe a trend toward Fascism is much more to be desired during the time of transition than one toward Socialism.

•

The intensity of current difficulties has at last aroused our latent energies, fired dormant purposes, and awakened powers which were sleeping. No longer are we chasing dreams and swallowing fallacies. We have come to recognize clearly that our ethical standards were never on a very high plane; that we were afflicted with an absurd personal vanity; that many of our leaders were unfit; that sales costs in numerous industries were never properly analyzed; that production was unbalanced and human effort misguided and misplaced; that in recent years two-thirds of the industrial wealth of the country has been transferred from individual ownership to ownership by the large, publicly-financed corporations, which vital change has not been accompanied by proper safeguards.

•

Let us hope that President Roosevelt has come to understand that the American people today are in a mood to follow blindly a genuine leader who has clear-cut ideas relating to underlying principles; who will take a determined stand on important matters; who will plainly indicate his willingness to sacrifice himself for his beliefs; who will show courage, human understanding, and honesty of purpose; who will not forsake his followers and never hesitate to alienate important groups of voters if that is the price he must pay in his fight for right.

Every great world catastrophe finally produces leaders who will not compromise concerning essentials; who have ability to work with others and get things done; who possess vision and idealism in a high degree; who have great dreams that are sound in fact and principle and that aim at the creation of new and better conditions.

If the new President of the United States possesses the qualities here set forth, our people will follow his banner, right or wrong, and we will win out in such conclusive fashion that the miseries of the depression will be largely compensated.

SOME
of your ARTHRITICS

whose pain and fever were under control in February are now subject to those spring recurrences which Tolysin, used promptly, will so effectively subdue.

DOSAGE:

2 to 3 five grain tablets as an initial dose with a glass of water, repeating in such quantities as to produce a daily dosage of 12 to 20 tablets. In the essential use of high dosage (especially successful in Acute Rheumatic Fever), the inauguration of rest periods after 60 tablets (300 grains) is probably indicated, during which, medication may take the form of Magnespirin, the improved Aspirin—or the common salicylates, followed by further courses with Tolysin. For chronics and children suitable reductions may be made.

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PHARMACEUTICAL MANUFACTURERS — Calco — DIVISION OF TOLYSIN

Gentlemen: Kindly send me a sample of **TOLYSIN**

Doctor.....

Address.....

City..... *State*..... MP4

MISCELLANEA

THE three topics most discussed where doctors meet together informally: contract practice, the Wilbur report, when will practice improve?

•

Queries on the last-named topic are usually put in a good-humored way. Physicians, on the whole—and in keeping with the spirit of the profession—seem to have accepted difficult conditions with extraordinary patience.

•

A common bit of repartee in times like these, runs:

"How are you today?"

"Fine—I can't afford to be sick!"

Though it obviously works hardship on the physician to care for people who cannot repay him for months, perhaps years; certainly every effort must be bent toward doing so.

It is a case of being all in the same lifeboat together, with the doctor doing rather more than his share of bailing. But the profession can ill afford to let patients get the idea that they must neglect their health because of doctors' bills.

•

There is a current story about a business man who was walking across a bridge. Spying a man about to leap over the rail, he rushed up just in time to stop him.

"Things can't be as bad as all that!" he argued, smiling optimistically. "Suppose we talk this over together."

So the two of them talked for an hour, at the end of which they both jumped.

The story is a tart commentary on the fact that about 20,000 suicides are reported annually in the United States. There is no telling how many additional suicides are prevented by an organization called The National Save-A-Life League, whose monthly bulletin "Save-A-Life" made its initial appearance in January.

The organization has existed since 1906, but is apparently being spurred on to greater anti-suicidal activities by present conditions. President and vice-president of the league are doctors of divinity. The treasurer is a physician, Dr. James F. Ackerman, Asbury Park, N. J.

Facts about the league's activity:

> During the last half of 1932, league workers interviewed 1,977 potential suicides, advanced arguments against self-destruction.
>
> The league last year gave out 6,416 meal tickets where they would have the greatest anti-suicidal effect.

In New York City the League maintains 24-hour telephone service, and is glad to send out a t r a i n e d representative with spiritual aid whenever a potential suicide is reported by a physician or the police.

•

Not only has the depression lowered prices generally, but it has forced manufacturers of many classes of products to use sharp ingenuity to find less expensive ways of manufacturing, and new markets. Some of the results: new vacuum cleaners, as reliable and efficient as the old, at half the cost; new oil heaters to suit the owner of the moderate-priced home; electric refrigerators to fit deflated pocketbooks.

One phenomenal example of this tendency that will interest hospital superintendents, clinic managers, and some physicians, is an ingenious new electric dumb-waiter, costing about half as much as former types. Sell-

ing for a price that would appeal to the individual house-owner, this new equipment can be installed with little fuss, operates with even more efficiency than the old, more costly types.

•

Eloquent of the times are these figures produced by one hospital in the East:

Full pay patients treated in 1929, 26%
Full pay patients treated in 1932, 18%
Part pay patients treated in 1929, 29%
Part pay patients treated in 1932, 28%
Free patients treated in 1929, 45%
Free patients treated in 1932, 59%

Probably many hospitals (as well as physicians) could produce figures showing an even more startling contrast than these.

•

"Every new automobile we turn out represents the equivalent of 71 days continuous employment for one man," says the general manager of a nationally known motor company.

Doctors can take their cue from this—especially those with money to purchase cars and other goods, who have avoided doing so at a time when it might seem unfitting to flaunt their buying power. Purchases now will help, not hinder, business recovery.

•

How many physicians' offices display on their walls that famous painting by Sir Luke Fildes: "The Doctor"? Familiar are the sick child, the faithful practitioner—weary from his all-night vigil—the anxious parents hovering in the background. Although many of the modern school painters would call the picture oversentimental, it has inspired many a physician with zeal, many a patient with reverence for the doctor.

It also appears that the painting has occasionally inspired a movie director. "The Country Doctor," a photoplay produced a few years ago, contained a scene more or less accurately reproducing the Sir Fildes painting with living characters. A modernized version appears in a current photoplay, "I Am Guilty of Love." Here, the well-known scene is staged in a city apart-

Modernized movie version of Sir Luke Fildes' painting, "The Doctor."

ment. The doctor (Actor Ralph Morgan) wears a winged collar, looks more like a pediatric specialist. The parents still hover in the background, but their back-patting action, considered a bit mawkish, has been omitted. Instead of a kettle on the stove, there is an electric vaporizer.

•

A new monthly periodical contributed free by a manufacturer of infant dietary products is called "The Little Journal for Pediatrists." Features: brightness of typography, informality (it chats on subjects remote from medicine), convenient arrangement of facts about the sponsor's products. Some point to it as another example of the new trend of pharmaceutical advertising—away from heavy, scientific literature, toward informality. The theory: physicians are as human as any other group of readers.

•

An Akron (Ohio) physician was sitting in a barber chair a few weeks ago. He was mildly surprised when the customer in the next chair reached over and handed him a dollar, explaining, "Here's something I owe you." The doctor was still more surprised when he returned to his office and found the exact amount —$1—entered in his ledger under December 6, 1916.

•

A pharmaceutical manufacturer recently sent out some elaborate packages of samples to a number of physicians. The manufacturer arranged to have the packages delivered by Western Union messenger, instead of by mail.

A timid physician in a Midwestern city received his package from the uniformed messenger, instantly viewed it with suspicion. He soon learned that no member of his family had ordered any package of the sort, so 'phoned the police. They arrived with screaming sirens, turned the package over and over, listening carefully for tell-tale ticking noises, finally called in a bomb expert.

The latter carried the package out to the city dump, gingerly unwrapped it, breathed his relief when the contents turned out to be medicine.

•

Ever know that one of the first sedan-type automobiles made (back in 1913) was named "The Country Doctor"? The car's manufacturer advertised that the model was suggested by a physician who did a lot of country driving and did not want a chauffeur.

•

Is the dictum followed generally that a good physician must study all his active life in order to remain a good physician? One prominent publisher of medical books is sure that a comparatively small percentage of physicians are "book buyers." He estimates that the market for new medical books of all kinds is limited to about 20,000 physicians. The rest, according to him, are just not interested. Surprising figures, if true!

•

Expectant mothers gaze dubiously at this sign in the Abington Memorial Hospital (Phila.): "Maternity Ward—No Children Allowed."

•

A panel in the lobby of the New York Academy of Medicine Library bears this inscription:

> To commemorate the many virtues and rare usefulness of Samuel Smith Purple.

The adjoining panel reads:

> In appreciation of the liberal gifts of Landon Carter Gray.

Official colors on the Academy flag are royal blue and white.

Child Guidance

ANOTHER FIELD FOR PREVENTIVE MEDICINE

By George J. Mohr, M.D.

A task confronting medicine just now is *to extend the use and frequency of periodic health examinations.* But, as many an M. D. has asked, "How?"

Scores of ideas have already been advanced. Most of these have been iterated and reiterated. Few are of any value.

Too often they are hopelessly impractical. Usually the working details are left out. Their originators seldom suggest actual plans of action. Hence, the ideas remain ideas, and nothing else. They flicker brightly for a moment, then die out and are forgotten.

This is unfortunate, because many of these ideas would succeed if they were concretely expressed. At it is, the majority are just generalities—interesting to talk about, but lacking in practical worth.

Physicians who expect to make any progress in preventive medicine, must have something tangible to work from when they approach this new sphere of practice. They require a definite starting point.

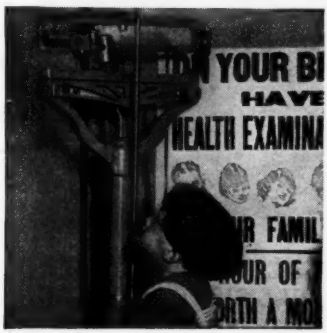
One such starting point is *child guidance.* Suppose we consider the opportunities this subject affords the medical man contemplating a future in preventive medicine.

As those active in the field can attest, child guidance is urgently in need of more positive action on the part of the medical profession. A greater interest is warranted in its clinical possibilities. *It needs more vigorous medical leadership, more and better equipped men to function within its ranks.*

It is to be regretted that adequate training in child guidance has been hard to obtain, and simply because medical schools as yet provide little in their curricula to equip the student along this line. Thorough training in psychiatry and some experience in pediatrics are essential for the physician who is successfully to function in the field of child guidance.

In his pre-medical training, such a doctor must become fairly well grounded in psychology and possibly in sociology. Moreover, he must be familiar with methods of social investigation.

Actually, this is not much to expect. The nature of the prob-



lems of child guidance demands no less of the practitioner. My personal feeling is that the general man who wants to do this work should be familiar with pediatrics and psychiatry, particularly the latter.

•

Speaking generally, child guidance may be considered from two major points of view:

1. In relation to the general field of mental hygiene, and
2. In relation to clinical medicine.

The belief has grown that proper educational and preventive treatment during early years will do much to reduce the incidence of these disorders, and will be much more effective than curative treatment after adulthood has been reached. Administrators in the field of penology and delinquency are practically unanimous in their conviction that current methods of dealing with the adult offender are of small value in a therapeutic sense. The answer, they believe, lies in more successful *preventive measures.*

As a result of this, great interest has been directed toward the problems of child conduct.

Paralleling this popular interest in child guidance have been certain developments in the field of medicine. In these we are more specifically interested.

The most pertinent changes are those that have taken place in psychiatry. Here, in the past twenty-five years, both theory and practice have been revolutionized. The psychiatrist today does not confine his interest to the psychotic under custodial care, any more than the pediatrist confines his interest to the hospitalized case of serious malnutrition or to the child with pneumonia.

The psychiatrical study of children in America first began by observing youthful delinquents in the juvenile court clinics. This was extended so widely, however, that today large groups of "normal" children, as well as many delinquent, unstable, and so-called "behavior problem" children, are being studied regularly and fruitfully by psychiatrists.

Similar developments have taken place in pediatrics. American pediatrics is largely a field for preventive practice. Avoiding the deleterious effects of nutritional and physical disorders by regulating the child's feeding and health habits has brought unhoped-for rewards in good health.

•

One of the most effective means for the study and treatment of child problems is through child guidance clinics.

In such a clinic, advantage is taken not merely of what the physician can discover for himself, but also of the data offered by several allied scientific fields.

To illustrate: Every physician secures a medical history in his study of a case. In the child guidance center, not merely a medical history, but a careful social study of the child's family and his training experience are made. Moreover, the child is studied psychologically, with the idea of determining his actual intellectual capacities and limitations. This study is made by a trained psychologist.

We all know that psychological tests have been discredited somewhat among physicians. There are two outstanding reasons. Too frequently these tests are applied by practitioners who have never had thorough training in their application and use. Furthermore, they are sometimes employed by psychologists who have been technically well trained so far as administration of the tests is concerned, but who tend toward a too rigid interpretation of rating and intelligence quotients.

Only by the proper use of psychological tests can the child's capacities be determined. Only in this way can it be discovered whether his achievements are in

keeping with those capacities, and whether measures taken to aid him in his difficulties are proving effective.

•

In the child guidance center every child is studied physically to determine whether there is present any actual defect or disease, and to evaluate the nature of the physical organisms.

By way of pointing out clearly the opportunity open to the general practitioner in the field of child guidance, this following list is appended. It indicates the types of cases and situations about which parents and schools seek advice regularly:

Difficulties in feeding habits of the young child;
Difficulties in training of bowel and bladder control;
Developmental difficulties involving speech;
Poor habits of sleep;
Temper display;
Excessive disobedience;
So-called "nervous habits," such as over-excitability, -tics, neurotic fears;
Behaviour difficulties following encephalitis, chorea, or other chronic infections;
Poor school progress;
Truancy from school or home;
Delinquent behaviour (stealing, lying, destructive behaviour, etc.);
Sex problems of the young child or adolescent;
Problems of adolescent instability (conflict between parents and their adolescent children);
Personality problems of the child or adolescent (shyness; timidity; fear; withdrawn, egocentric, or excessively aggressive behaviour);
Neurotic disorders of adolescence.

From a medical standpoint, these problems prove to be of the following general nature:

Disorders involving the central nervous system—
Birth injuries,
Encephalitis,
Chorea;
Disorders involving the endocrine gland system;
Problems of poor motor coordination;
Sensory peculiarities or deficiencies;
Poor habits of physical hygiene;
Actual retardation in mental development.

Other factors, not strictly medical, that the physician should be able to recognize in connection with these physical conditions are often of the following nature:

Parents' lack of information on methods of child training;
Immaturity or neurotic disturbance on part of parent;
Domestic discord involving parents;
Conflict between a child and his brothers and sisters or parents, based on rivalry or relative superiority or inferiority, as compared with siblings, or an ordinal position, parental favoritism, etc.;
Problems of over-protection and of rejection of the child by parents;
Problems involving exposure to delinquent or untrained associates.

The above listings are suggestive, rather than complete. Some may think that the problems enumerated are not for the physician. But the fact remains that they are the real problems presented to him by mothers seeking advice about their children. They appear to be everybody's problems, therefore nobody's if not the physician's.

I have tried to indicate that psychiatrists and psychiatric social workers in the child guidance field have developed definite investigative and diagnostic techniques. These are strictly in keeping with medical diagnostic procedure and psychiatric knowledge.

Like most problems, they are no longer confusing when understood.

Men died of a mysterious sort of "inflammation of the bowels" before surgeons developed knowledge and technique for dealing with appendicitis. So, too, children grow into practical failures, become delinquent or eccentric, possibly even psychotic, for reasons equally misunderstood.

In short, it is possible for the serious-minded general practitioner to recognize these problems, to isolate, to define, and to correlate etiological and provocative factors. If he himself can not carry out fully appropriate treatments, he can at least initiate them.

Child guidance, as a definite starting point in preventive medicine, is his, if he will but avail himself of it.

Nobody shakes a bandage bu

Shake the ordinary bandage over a smooth table top and you have all the scenic effect of Eliza crossing the ice.

Shake the BAYBANDAGE that does not ravel and no lint or dust or end threads are detached, which proves that BAY-BANDAGE has a permanent non-ravel edge. It makes a neater, more profes-sional dressing. It costs no more. Your dealer has it.

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Surgical Dealer .....

Patient's Consent

A LAWYER'S SUGGESTION FOR A PRE-OPERATIVE AGREEMENT

By Leslie Childs

EVERY doctor who has performed an operation or assisted at one has been conscious of the tremendous responsibility which surgery entails.

It is a two-sided responsibility—moral and legal. The moral phase, of course, is preeminently the more important, since no man who has not a genuinely professional sincerity, can be controlled by man-made law.

But the legal phase deserves careful thought too, for the doctor needs to protect himself against lawsuit.

There are patients who do not hesitate to take advantage of legal loopholes to encroach upon a physician's resources and reputation. Malpractice insurance may protect him financially, but it will not secure his standing in the community. (TURN TO PAGE 61)

AGREEMENT

I hereby employ Dr. John Doe to perform an abdominal operation upon me, for which I agree to pay a fee of $250. It is agreed that this fee is for the operation only, and that I will, in addition, pay Dr. Doe his customary charges for such after-treatment and attention as my condition may require. I further assume all liability for my hospital and nurse bills.

It is understood and agreed that, after the commencement of this operation, its scope and extent shall rest entirely on the sound judgment of Dr. Doe; and he has my consent to do whatever, in his judgment, appears proper and necessary for its successful conclusion.

Signature of patient.....

A contract form for the patient to sign before the surgeon operates.

Patient's Consent

(FROM PAGE 57) It is well settled that, except in emergency cases, the consent of the patient is essential before the surgeon can operate. Moreover, the latter is bound to confine the operation to the terms of the consent.

The importance of having a clear understanding with the patient is, therefore, obvious. To illustrate the possible danger to a surgeon in a situation of this kind, the following decided case is reviewed:

In Rolater v. Strain (39 Okla. 572, 137 Pac. 96) the patient consented orally to an operation on the great toe of her right foot. The surgeon undertook to perform the operation; and, after the patient had been placed under an anesthetic and the member opened, he discovered that the removal of a sesamoid bone was required if her operation was to be of benefit.

The surgeon thereupon removed the sesamoid bone.

Subsequently, the patient brought an action for damages, on the grounds that she had consented to the operation on condition that no bone be removed. The surgeon denied there had been any such agreement, but the plaintiff convinced the jury that the agreement was as she contended.

She was awarded a judgment against the defendant in the sum of $1,000. The case was appealed, and the higher court affirmed this judgment. Its decision was based on the following reasoning:

"The operation was not performed in the manner agreed upon and in the manner consented to by the patient [the court of course taking the jury's finding on this as true]. As a matter of fact, the actual operation performed was without her consent. . .It follows that, if the contract was made between the patient and surgeon, the patient had the right to insist upon a strict performance of it. The removal of the sesamoid bone by the surgeon was without the consent of the patient. It was therefore unlawful and wrongful, and it constituted a trespass upon her person . . . Judgment affirmed."

•

Other cases of this kind might be cited. But the above seems sufficient to bring out the point of this article, namely: that *the surgeon should protect himself by contract from possible liability for his operations.*

The exact wording of such a contract would vary in accordance with the circumstances involved. Hence, before employing a form of this nature, the physician should have it approved by his lawyer.

Care should be taken that all proper parties sign the agreement. For example, if the patient is a married woman, the signature of her husband should be added to her own, for the purpose of cutting off any right the husband might have to damages for injury to his wife. In the same way, the parents' signatures should be secured before operating on a child.

Of course, the question of who are the proper parties to sign a pre-operative contract will depend entirely upon the facts of each case.

To sum up, it may be stated that the use of the foregoing contract does not confer any greater authority upon the surgeon than he would ordinarily have if the patient unconditionally submitted himself for the operation. For, in such a case, the surgeon would possess implied authority to do whatever in his judgment was required for the welfare of the patient. Indeed, if he did less, he would be open to a charge of negligence.

On the other hand, there is no gainsaying the fact that by

LUBRICANT "McNEIL" SMOOTH-CLEAR-STERILE

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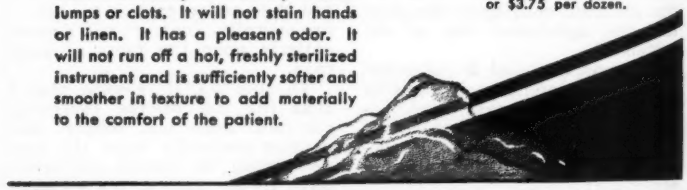
WILL NOT RUN OFF A HOT INSTRUMENT!

Physicians who try Lubricant *"McNeil"* continue to use it because its superiority is evident. The nozzle-tipped tube is easier to handle. The Lubricant flows from it smoothly and evenly without lumps or clots. It will not stain hands or linen. It has a pleasant odor. It will not run off a hot, freshly sterilized instrument and is sufficiently softer and smoother in texture to add materially to the comfort of the patient.

Lubricant "McNeil" has been approved by the Council on Pharmacy and Chemistry of the American Medical Association.

Your dealer has it in the standard, over-size tube that sells three for $1.00 or $3.75 per dozen.



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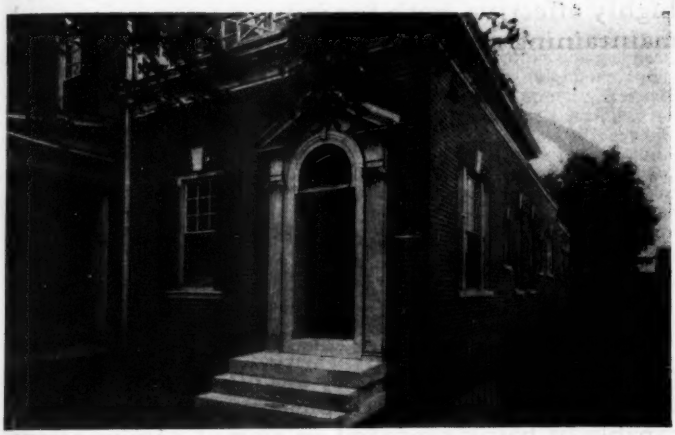
Name..... Address.....

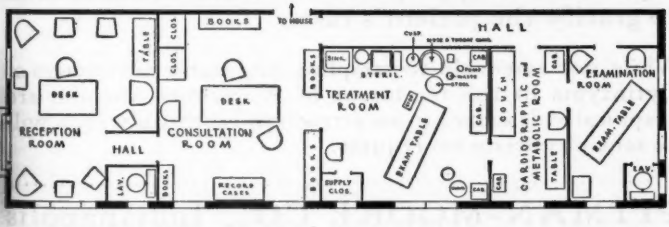
Dealer's Name ME-4

reducing the terms of consent to an operation to writing, the surgeon tends to preclude all after-dispute over *what the terms of consent were.* It enables him to operate without the spectre of a possible lawsuit hanging over his shoulder. It frees him from the possible charge that he exceeded his authority, in the event the operation does not fulfill the patient's expectations.

•

Home-office in Colonial design





A physician in Lancaster, Pennsylvania, built this 5-room office for general diagnostic work. The style of architecture is Pennsylvania Colonial, to agree with the older residence to which it was attached. The front entrance opens immediately into the reception room, where the secretary has her desk. A door from the consultation room leads into the doctor's residence. The land slopes downward from the street, so the office is two-stories high in the rear. The lower floor is used for a laboratory.

— *in Pernicious Anemia*

the desiccated gastric mucosa of swine has proved highly effective, both for inducing remissions and maintaining normal blood pictures.

CYTIN-ZYME

presents gastric mucosa, carefully selected and processed, in a product of pleasing palatability and capable of being prepared in varied combinations to gratify the patient's taste.

While not amenable to sampling, the many advantages of Cytinzyme in the treatment of Pernicious Anemia, are graphically described in an attractive brochure which will be sent physicians on request.

.....

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You may send me your brochure, Cytinzyme in the Treatment of Pernicious Anemia.

_____ *M. D.*

Address _____

City _____ *State* _____

Is John Doe a Deadbeat?

IF HE IS, OUR CREDIT BUREAU WILL WARN US

By Whitman C. McConnell, M.D.

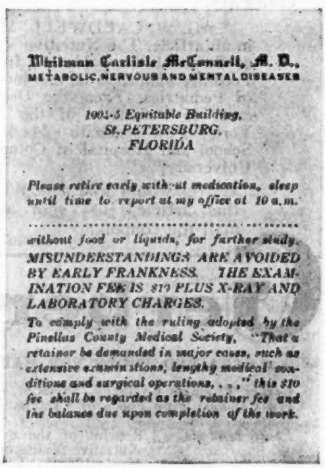
Today, when requests for long credit are especially frequent, it is more important than ever to know the patient's paying habits. This article describes a credit bureau organized for and by doctors. Its system appears to be unusually simple and efficient.

DOE, John, 123s4a 36 40 30 . . . Looks like a government secret service message, but it's not—merely a convenient, confidential method of designating a debtor-patient in the files of a credit bureau—the Physicians' Business Bureau, to be exact, of the Pinellas County (Florida) Medical Society.

Credit bureaus are cast, generally, in the same mold. But there are a few novel wrinkles in ours. To begin with, we do not restrict our membership to physicians. Associated with us is the St. Petersburg Dental Society, which has created the Dentists' Business Bureau. The files of this bureau and those of the Physicians' Business Bureau are available to members of both societies. The two bureaus are operated from one office, and their conduct is essentially alike. Generally, we refer to them together as "the bureau."

Before organizing our own service to deal with delinquents, we approached the local commercial credit bureau with the idea of obtaining membership. We found, however, that it would cost each physician or dentist $24 a year to belong—even at cut rates. Furthermore, we learned that a member could not get data on a patient by telephone, and, thus, could not apprise himself of a stranger's credit standing at the time of his first office visit.

So we gave up the idea of joining the commercial credit bureau, and decided to organize on our own behalf. The Supreme Court of Florida has ruled that "Merchants (physicians, since they sell service, are included in this class) have the right to organize for their own protection and to enter



Whitman Carlisle McConnell, M. D.,
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Please retire early, without medication, sleep until time to report at my office at 10 a.m.

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without food or liquids, for further study.
MISUNDERSTANDINGS ARE AVOIDED BY EARLY FRANKNESS. THE EXAMINATION FEE IS $10 PLUS X-RAY AND LABORATORY CHARGES.
To comply with the ruling adopted by the Pinellas County Medical Society, "That a retainer be demanded in major cases, such as extensive examinations, lengthy medical consultations and surgical operations. . . ." this $10 fee shall be regarded as the retainer fee and the balance due upon completion of the work.

The author's appointment blank carries a notice of the retainer.

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and Mineral Deficiency Diseases

★"THERE is no doubt but that in many children there is an inadequate supply of (these) minerals, since in the home preparation of vegetables the major portion of the minerals and vitamins are often destroyed.

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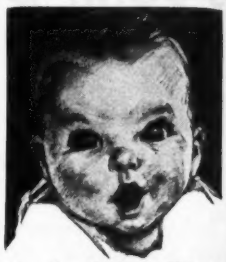
★G. W. CALDWELL, M.D., in an article, The Nutritive Value of Strained Vegetables in Infant Feeding, published in the Journal of Pediatrics. From the Department of Pediatrics of the New York Post-Graduate Medical School and Hospital of Columbia University.

If you would like a copy of this article, just sign and mail the coupon.



In the Infant Dietary *Gerber's Strained Vegetables* Provide

Maximum Vitamin and Mineral Salt Values. All operations are performed in air-excluding vessels. Reduction to proper consistency in sealed vacuum pans, avoids the loss of mineral salts that occurs when cooking water is thrown out in the home.

Regularity in feeding. The Gerber process assures utmost uniformity permitting physicians' schedules to be followed accurately in the home. The Gerber Products are ready-to-serve when warmed and seasoned, as the doctor directs.

Proper Texture. Monel metal screens remove coarse, indigestible fiber. The Gerber Products can be fed thru a nipple as a part of baby's milk feeding.

Gerber's Strained Cereal. A starting cereal made of whole wheat, hulled oats and added wheat germ, long-cooked in whole, fresh milk. Coarse bran particles are strained out after their nutrients have been cooked into the cereal. Ready-to-warm and use. Season as doctor directs.

If you would like to examine this newest Gerber product, we'll gladly send a sample can free. Just fill in coupon below and mail.

15c at Grocers and Druggists

Gerber's *Strained* Beets—Carrots—Peas—Green Beans Prunes—Spinach—Vegetable Soup—Tomatoes. 4½ oz. cans.

Gerber's *Strained* Cereal 10¼ oz. cans.

Gerber's

9 STRAINED FOODS FOR BABY

Gerber Products Company, Fremont, Mich
(*In Canada*) Fine Foods of Canada, Ltd., Windsor, Ont.

Please send me,

☐ Reprint of the article, The Nutritive Value of Strained Vegetables in Infant Feeding.

☐ Sample can Gerber's Strained Cereal.

Name .....

Address ME29

into a mutual agreement for the purpose of giving each other the benefit of their knowledge about those in the community who meet their obligations promptly, and about those who do not. A communication on this subject, made by a member of the association to the other members, is privileged if made in good faith and in such a manner and on such an occasion as to serve properly the purpose of the association."

Accordingly, we sent out a special announcement, calling a meeting of the county societies to take action on the motion. When the meeting took place, the members showed themselves highly enthusiastic. There was no opposition, and the motion was passed immediately.

Our first step after this was to purchase a second-hand addressing machine, 3,000 stencils, and 100,000 3" x 5" cards (of which there are but a few left today). Then we asked our one hundred members to give us data for publication on their delinquent accounts. The bureau was promptly swamped with replies, and after a considerable amount of labor, the mass of names was alphabetically arranged.

As fast as they were recorded, these names and the data concerning them were distributed for individual filing in the offices of the members. The best way of doing this, we decided, would be to print each name on a separate card. And, to avoid embarrassment in case of loss or theft, we printed all except the name in code. Thus, the notation in the first paragraph of this article, referring to Doe, John, 123s4a 36 40 30, means that Mr. John Doe of 123 Fourth Avenue, South, St. Petersburg, Florida, owes Dr. No. 36 $40, the year when he last

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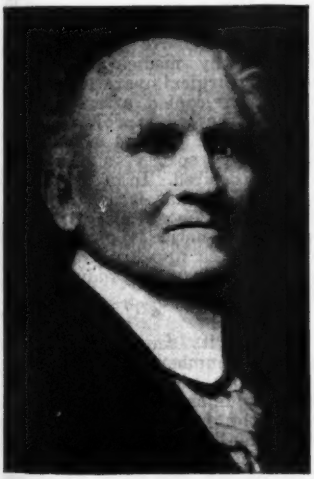
America's first appendectomy?



This is Dr. Abraham Groves, eighty-six-year-old physician of Fergus, Ontario, who is given credit by many with having performed the first appendectomy on the North American continent.

He was recently honored at a dinner in his home town, which was attended by more than four hundred patients, neighbors, and friends.

When Dr. Groves was graduated from medical school and entered active practice, in 1871, Lister was just beginning to make known the truths of asepsis.

received medical service being 1930.

When an account is paid, the creditor sends in a request to withdraw the debtor's card from the bureau's next published list. Recently, to economize on time and material, the bureau has been issuing additions and subtractions on mimeographed forms so that office secretaries may help by maintaining their own files and decentralizing the work. This plan would have been ineffectual until the card system was well established for the reason that lists that are not transferred immediately to the cards are obsolete by the time they are published. The card system, on the other hand, is always up-to-date.

•

The fact that we keep a reference file of delinquent accounts is not made secret in our community. On the contrary, members often warn their debtor-patients that the business bureau is about to publish their names. This action brings results in about ten per cent of the medical cases and in about twenty per cent of the dental cases.

A ruling of the county society states that a retainer fee must be demanded in major cases—that is, for extensive examinations, for lengthy medical conditions, and for surgical operations. This ruling we copied after the custom of the legal profession. It rests on an official decision of the county society, and may be used as desired. In my own practice, I find that it assures final payment of most bills for major work. A notice regarding this retainer fee appears on my appointment form, reproduced with this article.

•

Basing its conclusions on the average number of accounts received per physician, multiplied by the number of physician-members, the bureau has estimated that the seventy-five doctors in our society have over half a million dollars due them from pa-

tients. This is a tidy sum, even when divided by seventy-five. Most of it would have been collected had our bureau been in operation before this mass of debts had time to accumulate.

But no use crying over spilled milk. At least, in the future, we are assured of adequate protection. Honest individuals in our locality heartily approve the methods of the bureau. Physicians' credit has advanced considerably among merchants.

Of course, a good many delinquents howled persecution when the bureau was first started. But since their wailings fell upon the ears of unsympathetic listeners, they eventually quieted down. Meanwhile, they had given us a lot of valuable free publicity.

No restrictions have been placed on members of the bureau, because professional men instinctively chafe under hard-and-fast binders. Rather do we rely on the protective instinct to keep our credit system going.

Members know that the only way to spare themselves credit losses is to secure advance information on all non-emergency cases. They are also aware that they cannot get this information without united action. Hence, they cooperate. Hence, patients pay their bills.

And this is the only way any credit bureau operated by medical men can be expected to succeed. Close teamwork is the keynote of its continued usefulness.

To any group of physicians elsewhere in the country who wish to organize their own credit bureau, let me suggest these steps in the process: First, convince yourselves that such a privately operated bureau is what you really want. In some sections a good commercial credit bureau may prove the more practical choice.

Next, draw up your working plans in their entirety before making a move. Then, if you still see fit to proceed, get the approval of your county society.

Birthday Letters, Too

SUPPLEMENTING DR. SEGNER'S ARTICLE, "THE BIRTHDAY BOOK"

By N. Thomas Saxl, M.D.

IN the February issue of MEDICAL ECONOMICS appeared an article by Dr. Kenyon B. Segner, called "The Birthday Book." I read this with great interest because I, too, adopted several years ago the idea it discussed of sending birthday cards to child-patients.

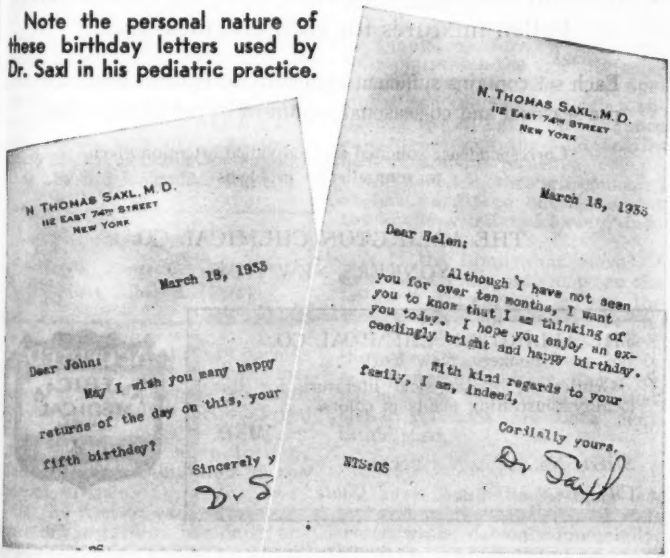
My experience has been totally different from Dr. Segner's, so I shall explain here what results were obtained with the plan, and how I modified it to conform with my own requirements.

When the birthday card idea first occurred to me, I welcomed it as the long-sought, ideal follow-up.

At once I had cards made up by my engraver and began to send them to all my young patients. In fact, I devised a system so that my secretary would automatically mail each child a card at the proper time.

Nevertheless, as time passed, I had to admit that the reaction was decidedly cold. Rarely did a patient comment, rarely was I

Note the personal nature of these birthday letters used by Dr. Saxl in his pediatric practice.



N THOMAS SAXL, M.D.
112 EAST 74TH STREET
NEW YORK

March 18, 1933

Dear John:

May I wish you many happy returns of the day on this, your fifth birthday?

Sincerely y

Dr S

N. THOMAS SAXL, M.D.
112 EAST 74TH STREET
NEW YORK

March 18, 1933

Dear Helen:

Although I have not seen you for over ten months, I want you to know that I am thinking of you today. I hope you enjoy an exceedingly bright and happy birthday.

With kind regards to your family, I am, indeed,

Cordially yours,

NTS:OS

Dr Saxl

even thanked for my remembrance.

It appeared that the mistake in the system was *lack of personal touch*. The greeting seemed too businesslike to the patient. Accordingly, I decided to try *personal letters* instead. These were sent to new patients as they were received in my practice. The use of cards was continued for the ones who had received them before.

Few doctors have the time to write birthday letters by hand. Consequently, I had to rely on the tact and efficiency of my secretary to do it for me. She was instructed to vary her letters every year, so that patients would realize they were not simply form letters. This she has done for the past seven years, and the results have been most favorable.

The bookkeeping entailed in such a system is simplicity itself. Instead of the birthday book used by Doctor Segner, we use a system that works as follows:

In my secretary's desk is a 2" x 3" card file, labeled "Birthdays." This file is divided by guides into twelve sections, each guide bearing the name of a month, and followed by cards for days of the month on which birthdays occur. One of these cards which I have taken at random from the file looks like this:

APRIL 21

Davis, James C. (1924)
Gilbert, Albert S. (1926)

The year the child was born is always included, as shown. I believe it more intimate to mention the third, fifth, or whatever birthday it happens to be. In my opinion, it shows more thought than the mere tabulation of the date of birth.

On the first of each month, my secretary enters on her daily appointment pad, one day in advance, the letters to be sent out for that month. This gives her the opportunity of looking up last year's letter, so that she will not repeat the same phraseology in the new letter.

The birthday letter system, immediately after I began it, elicited a type of response wholly different from that I had been receiving. Its advantages have been five-fold:

1. The children who get these letters are delighted to receive mail. They are also glad to know that their doctor has remembered their birthday. In cases of very young infants, the parents are pleased. They enter such correspondence, they have told me, in their "Baby Book."

2. Months may have passed since the patient was last in the office, but the letter serves as a reminder to the parents of my existence and continued interest —else why would I have remembered their child's birthday? It has even retrieved cases which, I feel sure, would otherwise have drifted away.

3. Parents write or telephone to thank me for these letters. This maintains the friendly relationship between the child specialist and the family. Such a relationship is built up as once existed between the "old family doctor" and his patients.

4. Then, too, through comment of one parent to another about the birthday letter, I have gained new patients.

5. If the family has moved, I again locate my patient when the letter is forwarded. Then the parent telephones to thank me and to tell me how sorry she is that she forgot to inform me of her change of address. She gives me her new location, and professional relations are once more established.

•

I have found the birthday letter system inexpensive and well worth while, not only financially, but from the standpoint of goodwill and friendship.

Food Quality for the Convalescent Child

After debilitating diseases or operation there are impediments to the normal processes of nutrition. Appetite is often poor or precarious, digestion often impaired, and there is that condition of stomach erethism so frequently found in convalescence.

At such a time it is food quality that counts. Ovaltine adds food quality to the regular diet of the convalescent.

Ovaltine reinforces the diet with the appetite-producing and antineuritic vitamin B. It supplements valuable proteins, carbohydrates and fats. Its minerals, notably iron, calcium and phosphorus, help to bring about remineralization, indispensable in convalescence. It greatly increases the nutritive value of milk, makes it far more acceptable to the jaded palate, and what is of the utmost importance, breaks up the heavy curd of cow's milk into a light, easily digested coagulum.

Ovaltine should be given to the convalescent child at mealtimes, and always as a warm drink just before retiring to induce sound, refreshing sleep, so important in convalescence.

If you are a physician, dentist or nurse, you are entitled to a regular package of Ovaltine, which can be obtained by filling in the coupon below.

This offer limited only to practicing physicians, dentists and nurses

THE WANDER COMPANY
180 No. Michigan Ave.
Chicago, Ill. Dept. No. M. E. 4
Please send me without charge a regular size package of Ovaltine for clinical trial.

*Dr.*_____

*Address*_____

*City*_____ *State*_____

Canadian subscribers should address coupons to A. Wander, Limited, Elmwood Park, Peterborough, Ont.

OVALTINE
The Swiss Food-Drink
Manufactured under license in U. S. A. according to original Swiss formula

The Marion County Plan

OUR MEMBERS ARE PAID FOR SERVICES TO POOR

By Corwin S. Cornell, M. D.

The author of this article is secretary of the Marion County (Iowa) Medical Society. The plan he describes here for rendering service to the indigent sick presents more evidence that the county medical society can function as an economic as well as a scientific arm of the profession.

MEMBERS of the Marion County Medical Society feel that they have found one answer to the perplexing problem of medical services for the poor. Our plan—known as the Marion County Plan—assures the reimbursement of physicians for services to the indigent, and, of equal importance, the equal distribution of this work among the physicians in the county.

Until comparatively recently, services to the indigent in our district were on a hit-or-miss basis. Two of the fifteen townships of the county had township physicians, i.e. members of the medical profession who contracted with the board of supervisors to render services to the poor within their respective areas for a fixed sum each year. In addition, there was a county farm doctor also under contract. The services rendered by the other physicians—the rank and file, so to speak—were rather extensive; but remuneration was another question. Individual bills for medical services were either cut in half or rejected altogether when presented to the county board for payment.

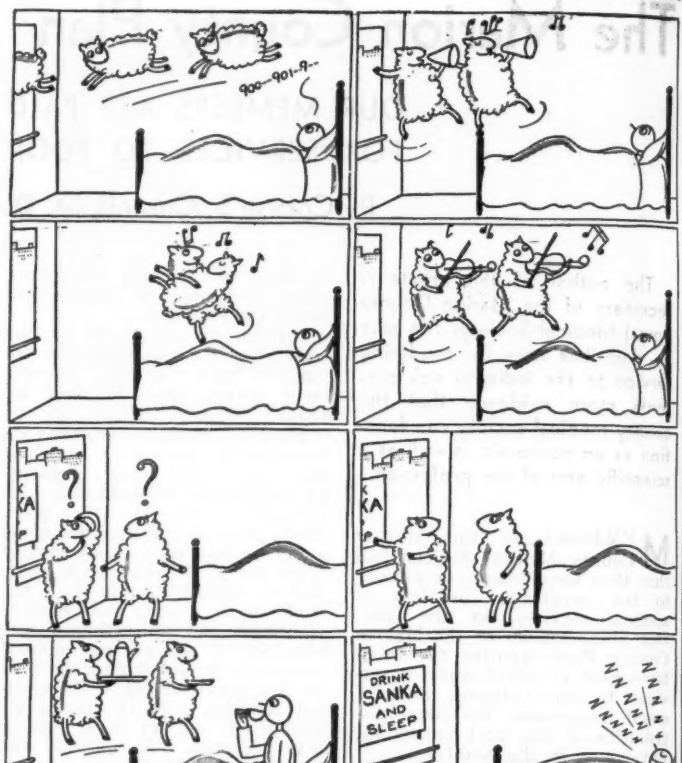
On various occasions at our county society meetings, the fee question was discussed. Finally came action. Here is what we did:

First we incorporated, then we interviewed the county board of supervisors who readily consented to advertise for bids to render medical services to the poor. Then, as a corporation, we made a bid to take care of all charity work for a flat sum each year. Before submitting our bid, the books of the county auditor were consulted and an estimate was obtained of the average annual amount expended during the four or five previous years for medical services. On this basis we submitted our proposal, which was accepted. A contract was signed and a bond given.

The procedure proved to be practical, and has continued for several years. Our method of dividing the money paid to the society by the county is as follows:

Each service rendered by one of our members is recorded on a uniform county claim blank, itemized, and endorsed by the county social worker or a township trustee. All these claims are filed with the county society secretary, and audited by a committee of five each year.

The state and county society dues for each member are first deducted, as [TURN TO PAGE 124]



Sanka Coffee doesn't really provide nocturnal sheep-butlers. But it *does* provide *real* coffee with 97% of the caffein removed. It doesn't *put* you to sleep, but it *lets* you sleep. That's why many physicians drink Sanka Coffee themselves. And why they recommend it when they want patients to give up caffein without giving up coffee. It's a product of General Foods.

GENERAL FOODS, M. E. 4-33
Battle Creek, Mich.

ACCEPTED AMERICAN MEDICAL ASSN. Commission on Foods

Gentlemen: Please send me without charge a ¼-lb. package of Sanka Coffee—also the booklet, "The Passing of 'Thou Shalt Not.'"

Name_____

Street_____

City_____ State_____

This offer not good in Canada.

The Doctor and His Investments

By WILLIAM ALAN RICHARDSON

Author's Note: In making specific investment recommendations, I can not urge too strongly the following precautions: FIRST, be sure that you are fully protected by life, disability, and other necessary insurance; SECOND, create an emergency bank reserve sufficient to cover six months' professional and personal expenses; THIRD, study carefully the general principles of investment discussed in these pages each month, and apply all specific advices accordingly.

CONFIDENCE — that fragile shrub—has sprouted again.

And why not? Banking clouds have lifted, 3.2 beer is proving a good fertilizer, and parasitic government weeds have been uprooted to clear the way.

The ground is prepared. What remains to be seen is whether public faith will hold up. Business and financial storms will undoubtedly descend now and then in the months ahead.

I believe that we are approaching more prosperous times. Security prices are bound to rise and fall nervously; but, from the long-term standpoint of the physician, their trend is *up*. This conclusion is not based on *blind optimism*, but on *careful analysis*.

Market forecasting, by its very nature, rests on guesswork. But a vast difference exists between *blind* guesswork, and the kind based on an interpretation of *facts*. Which of the two is preferable, the reader may judge for himself.

We recognize in these times the need for concreteness. The hazy generalizations being bandied about engender confusion—nothing more. To be specific, therefore, what reasons are there for assuming that the market will move up from now on, rather than down?

The first reason is *improved public sentiment*. It may dim at times, but the probability is that it will brighten more than it will fade.

Behind this comes an *aggressive administration*. If it continues its stacatto of public remedies at only half the present speed, Wall Street bears won't have a chance.

A third cause for market optimism is the *mild inflation* in prospect. Extended bank credit and the floating of large government bond issues promise to bring this about. As dollars become more plentiful by this process, the natural tendency will be for prices of tangibles to rise. Common stocks, of course, represent an interest in these tangibles (manufacturing plants, machinery, commodities, etc.); hence, their quotations will enjoy a sympathetic upswing.

Reduction in government expenses (including veterans' allowances) and the new *beer tax* constitute the fourth cause expected to affect security prices favorably. The public, with its

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is NOT advertised to the Laity . . .

We do everything we humanly can to prevent it.

FOR INSTANCE, here is an advertisement that we ran in the January issue of American Druggist—reaching over 50,000 druggists in America.

TAUROCOL has been manufactured for 28 years exclusively for physicians' use—both dispensing and prescribing.

TAUROCOL is a combination of bile salts with cascara sagrada and phenolphthalein . . . laxative, cathartic, increases peristalsis, increases flow of bile, stimulates bile producing cells of the liver.

and

VERA PERLES

of Sandalwood Compound —for inflammation of mucous membranes, particularly of the urinary tract—another Plessner product.

SEND COUPON TODAY

THE PAUL PLESSNER CO., Dept. M. E.
3538 Brooklyn Ave., Detroit, Mich.

Yes, please send samples.

.....M.D.

.....

.....

customary flair for round numbers, has selected $1,000,000,000 as the total benefit to be derived from these legislative steps. Although this figure is greatly exaggerated, the actual saving and revenue likely will go a long way to bolster government stability, public enthusiasm, and stock and bond prices.

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The foregoing are the four main reasons for assuming that the basic trend of the market will be up from now on. There are obstacles in the way, of course. But their combined effect, as I see it, will not be sufficient to divert the slow upswing in security prices any more than temporarily.

Among these obstacles is the *municipal bond dilemma*. Almost one billion dollars' worth of these issues are said to be facing default. Every effort is being put forth to avert this possibility, fortunately, and it looks as though the majority of weak municipals will be able to squeeze through without casualties. No legislative action has been taken in Washington. Rather are the municipalities themselves discussing the situation with their bondholders and concluding individual adjustments locally.

Obstacle Number Two, to be overcome before stock prices can advance appreciably, is *industrial sluggishness*. Heard today more than ever is the old query: "How's business?" From the standpoint of activity and volume, business is stagnant. Sub-

Investment Guide for April:

The doctor with about $5,000 to invest may safely hold:

20% in short-term U. S. Government bonds; 20% in underlying first mortgage bonds of public utility (phone, gas, light) operating companies; 10% in guaranteed first mortgage certificates on improved urban real estate; 20% in common stocks of chain-store, food, cigarette, and public utility operating companies; 5% in building and loan shares; the remainder in cash.

The doctor with about $20,000 to invest may safely hold:

25% in short-term U. S. Government bonds; 15% in underlying first mortgage bonds of public utility (phone, gas, light) operating companies; 5% in industrial bonds; 5% in guaranteed first mortgage certificates on improved urban real estate; 25% in common stocks of chain-store, food, cigarette, and public utility operating companies; 2% in building and loan shares; the remainder in cash.

The doctor with about $80,000 to invest may safely hold:

20% in short-term U. S. Government bonds; 5% in tax exempt municipal bonds; 10% in underlying first mortgage bonds of public utility (phone, gas, light) operating companies; 5% in industrial bonds; 10% in guaranteed first mortgages on improved urban real estate; 25% in common stocks of chain-store, food, cigarette, and public utility operating companies; the remainder in cash.

stantial improvement will probably not arrive until late summer.

A list of twenty-three indexes covering production, trade, prices, and finance, shows that business activity (as of March 29) is but forty per cent of normal. To cite specific examples: output of automobiles has been seriously hindered; public construction is quiet; private building continues only slightly more active; electric power output and the volume of carloadings are both down.

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Physicians who have been following the Investment Guide published with this article every other month will notice that no change has been made in it for April. From a long-term standpoint, I believe it comprises as well-balanced an investment formula as is possible in the light of existing conditions. Like a ready-made suit, it will not fit each wearer equally well. Allowances must be made in all cases for such variables as age, number of dependents, and individual requirements.

Physicians who have been basing their market decisions on the Investment Guide were gratified by the way in which the classes of stocks it recommends advanced in the rally that began when the New York Stock Exchange reopened on March 15. Prominent among the shares to

lead the advance were those of chain-store operators, utility companies, food manufacturers, and cigarette producers—the three classes of stocks advocated in the Guide. American Telephone, an operating utility, led the upswing by a five-and-a-half-point rise the first day trading was resumed.

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Now a few words about bonds. Government bonds and other high grade obligations should be retained only in moderate amounts. They do not deserve to be held for their possibilities of price appreciation, but as an ultra-conservative backlog, a balance to offset less gilt-edged stocks and secondary bonds.

Loyalty on the part of the investor toward prime-quality bonds has been well rewarded in the past three and a half years. It should be remembered, however, that these securities have risen almost as far as they will go, and that, with the changing cycle, superior profit opportunities are becoming available in sound medium grade bonds and in the more carefully chosen common stocks.

I have been asked a number of times why the advance of top-grade bonds is now approaching its end. Here's the answer:

A number of additional government bond issues are to be distributed within a short time, as I have already pointed out. When the supply increases and public appetite for them is sated, the prices at which they can be sold must necessarily fall below present levels.

There is also a technical reason why government bond (and high-grade bond) prices cannot rise much higher: As more of them are placed on the market, the terms under which they can be disposed of will naturally be less favorable to the government. In consequence, higher interest rates will have to be paid to the public. It is a time-tested principle that

as interest rates increase, prices of top-grade bonds drop.

•

Now, turning our attention toward stocks, what are their prospects for a rise between now and the fall? In brief, prospects are not at all exciting; although it is to be expected that stocks will, in the aggregate, move upward more than they will move downward, And a small profit is better than none.

In the same way that the price movements of government bonds approximate those of other first-quality bonds, so common stock and secondary bond prices parallel each other. The latter are the two principal classes of securities that I believe are going to reflect most sensitively any improvement in general business.

In selecting *secondary* bonds, for purchase from the groups listed in the Investment Guide (namely: industrial and public utility operating concerns), the reader is advised not to choose an issue having a Moody's rating of less than *Baa*, or a Standard Statistics rating of less than *B plus*.

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Investment Books for The Doctor's Library:

Inasmuch as several articles and considerable space have been allotted in this issue of MEDICAL ECONOMICS to a discussion of books for the physician, I am including here brief reviews of the newer, more worthwhile volumes on investment. For the doctor who buys and sells securities without professional guidance, a study of such books is virtually essential if he expects to attain any appreciable degree of success.

Principles of Investment by John E. Kirshman ($5, McGraw-Hill Book Co., New York)—A veritable encyclopedia of investment knowledge. Will answer practically any question on the subject. Explains how to plan an investment policy, how to carry it out.

The Selection and Care of Sound Investments by Arthur H. Herschel ($4, H. W. Wilson Co., New York)—Written from the investor's own standpoint. Tells what kinds of securities to buy, what to sell. Explains how the individual may supervise his personal stock and bond list.

Stock Market Theory and Practice by R. W. Schabacker ($7.50, B. C. Forbes Publishing Co., New York)—Probably the most complete reference book of stock market knowledge ever published. Nine hundred pages of closely-packed information. Especially instructive passages on chart-reading, "technical" market action, security analysis, brokerage houses. [TURN THE PAGE]

Investment and Speculation by Lawrence Chamberlain and William H. Hays ($3, Henry Holt & Co., New York)—The speculator and the investor set up side by side, defined, and analyzed. A constructive technique outlined for each.

Everyman and His Common Stocks by Laurence H. Sloan ($2.50, McGraw-Hill Book Co., New York)—A general treatment of common stocks as investments, drawing valuable conclusions for the physician interested in developing a sound, long-term investment program.

The Work of the Stock Exchange by J. Edward Meeker ($5, Ronald Press Co., New York)—The mechanical details of security transactions: how to go about making a purchase or sale; explanation of stop-loss orders, odd lots, buying on margin, bid and asked prices, puts, calls, etc.

Analysis of Financial Statements by H. G. Guthmann ($5, Prentice-Hall, Inc., New York)—Ways to judge the worth of any company or institution. Essential knowledge in these parlous times! Every security owner, insurance policyholder, and bank depositor will benefit by reading this volume.

Unmasking Wall Street by John Lloyd Parker ($2.50, The Stratford Company, Boston)—Exciting adventures behind the scenes with Wall Street's "mystery men": Durant, Drew, Meehan, Livermore, and others. Plus the sensational story of Ivar Kreuger.

How to Invest for Income and Profit by Edgar T. Brainerd (The Magazine of Wall Street, New York)—A simple introduction to the elements of investing. Opportunities in each of the major industries appraised.

Tape Reading and Market Tactics by Humphrey B. Neill ($3, B. C. Forbes Publishing Com-

pany, New York)—Valuable because it shows how to analyze market movements and how to gauge one's own investment position accordingly.

What Makes Stock Market Prices by Warren M. Hickernell ($3, Harper & Brothers, New York)—Professional pools, short-selling, corners—how they affect the small investor. Preventive medicine for those anxious to avoid losses in the market!

Common Stocks and the Average Man by George Frederick ($4, The Business Bourse, New York)—A 377-page footrule for measuring the worth of investment securities. Replete with tests, charts, analyses, plans.

Investment Trusts Gone Wrong! by John T. Flynn ($1, New Republic, Inc., New York)—An exposé of the investment trust idea. Reads like a novel. Includes a section on how to select a sound investment trust.

What to Consider When Buying Securities Today by A. T. Miller (The Magazine of Wall Street, New York)—Lessons in the selection of an ideal investment list.

The Doctor and His Investments by M. S. Rukeyser ($2.50, P. Blakiston's Son & Co., Philadelphia)—Financial policy and technique for the investing physician.

Stock Movements and Speculation by Frederic Drew Bond ($2.50, D. Appleton & Co., New York)—Clear-thinking interpretation of the reasons underlying security price fluctuations. Considered by several authorities the best book on the subject.

The Dow Theory by Robert Rhea ($3.50, Barrons, Boston)—Outlining a practical theory of market operation that has stood the test of twenty-five years' continuous use. Particularly appropriate for the seasoned investor.

PERALGA

Relieves pain but does not incapacitate by causing drowsiness. Quiets nervousness but leaves no mental confusion in its wake. PERALGA is not narcotic. Relief from pain and its nervous manifestations is obtained by the synergistic combination of amidopyrine and ethylmalonylurea in fusion. Headache, neuralgia, rheumatic pain, the discomfort of febrile diseases, the pain of dysmenorrhea, post-operative pain, are all quickly relieved by Peralga. Ask for a supply of Peralga for trial.

SCHERING & GLATZ, INC. 113 West 18th St., New York City

The Children's Clinic

(FROM PAGE 26) An inexpensive slide, a tray knocked together out of smooth boards and filled with gravel from a neighboring pit, and a cheap set of croquet mallets, balls, and wickets, completed my provisions for outdoor occupation. Sand pails and shovels, a rubber ball or two, and occasional toys were added from time to time, sometimes by appreciative mothers, sometimes as workers in the clinic saw the need of them.

All this was placed close to the door of the downstairs waiting room, so that it was possible for the accompanying elders to sit in the cool indoors and read magazines or chat together, meanwhile keeping a wary eye on their youngsters engaged in play just outside.

The noise that would have been unbearable had the children been romping indoors, was just another street noise when relegated to the playground where it belonged. And mothers who had dreaded the long, tiresome wait with restless, bored children, snatched a needed respite while the youngsters amused themselves after nature's age-old fashion.

In a pediatric practice where more work is done for the well child than the sick one, it is particularly necessary to have a clinic to which children like to go. While a mother will carry an ill or hurt child to the doctor's office whether he wants to go or not, it is quite a different story when the service to be rendered is "nothing more than a vaccination."

In addition to this feature which greatly helps the attendance, there is another one—every bit as important.

Many children—and the fact should be true of any pediatrician's office—are brought in because of behavior problems, conduct disorders, or other difficulties. When dragged into the ordinary doctor's office, they are ill at ease and embarrassed. They do not appear in their true character.

But place such youngsters in a playground, especially if other children are present, and they soon become their own customary selves, exhibiting some of the traits for which their parents have brought them in.

Attendants get into the way of observing them at play; and many a useful hint have I picked up from comments they made to me. Not infrequently, they will call me to come out of the examining room or the consulting room to see how this boy or girl is acting on the playground. I should hardly know how to practice pediatrics without this very valuable asset.

Granting the old adage that "handsome is as handsome does," however, I was still far from having "an attractive office" in the raw, ugly little cube that used to lean so close to the passers-by on the street.

Something had to be done. Lots of paint and a planting of evergreens, together with the laying out of a flower-bed next to the house, helped. But there was still

room for improvement. And I did not know just what could be done about it.

Last year I took the obvious step—the step that every doctor is constantly urging upon his patients. I consulted an expert.

I called upon a landscape gardener to take what I had, add to it, rearrange it, do whatever could be done without the outlay of a great deal of money. I told him to make the whole layout not only more attractive, but more commodious and more efficient as well. He did it.

The plan and sketch at the beginning of the article show how this was accomplished. The bold outline of the house, with nothing to break its prominence in front, has been softened by the transplanting of a large maple, dug from a neighboring field and towed in on a home-made trailer by my faithful car-of-all-work. This provides shade, and blends the building into the landscape.

Evergreens properly grouped about both front and side entrances relieve the ugly lines of my little jerry-built box. They even hint at the little English and Continental small-town buildings that crowd the narrow streets over there.

Enough hardy perennials to give a continuous bloom crowd the tiny beds bordering the brick-paved walk; and any spaces that were left have been sown with bright colored annuals for cutting. All the rooms of the clinic are kept gay with these during the spring, summer, and fall.

As will be seen by consulting the plot plan, the playground for the younger children is located just outside the waiting-room door, where mothers can keep an eye on the activities of their youngsters, and curb any feats that seem to them too ambitious for the performers.

Between this and the street, on a level slightly above the playground but still well below the street level, is a space upon which is built a large sandbox. This

has a cover for keeping the sand dry in wet weather, and is used to store the toys and utensils safely at night.

The side of the bank, leading up from this to the grass plot on the street level, is densely covered with honeysuckle, which in this latitude grows like a vigorous weed and has to be kept clipped to keep it from engulfing everything else. Trimmed thus, it makes a gorgeous mantle of green, with an odor that in the house would be overpowering, but outside is truly delightful.

Perhaps the feature about this playground most appreciated by parents as well as by myself, is its safety from street dangers. It is necessary that the clinic be accessible, and preferably that it be located just where it is—upon the highway.

But Highway Number Ten—as may be gathered from its nickname, "the Main Street of North Carolina"—is heavily and not always sedately traveled. Many a time I have rejoiced at this safety feature of my playground, especially when I have seen a passenger car dash by at reckless speed, or heard a heavy truck rumble past.

A wide stairway, with very low risers and broad treads, leads all patients from the street level down between the sandpile and the house itself, to enter the door of the waiting room. A gateway at the top is kept closed; although with all that is going on at the lower level to attract the youngsters, there is not much need of this added precaution.

The sight of the active playground is usually sufficient to dispel any gloomy forbodings that may have been indulged in relative to "going to the doctor's." And the youngster can be counted on to take a fling at some of the diversions provided for him. Thus, he forgets the things he has been dreading, long before it comes time for him to go inside.

•

There is still abundant space behind the smaller children's playground for games and sports for the older ones.

This area is sodded with rich, deep grass. The lawnmower man and the fertilizer merchant have given it up in despair, thanks to the attentions of a neighbor's cow, who abundantly pays for her grazing by constantly improving the ground cover.

In one corner of this open space has been built an inexpensive but lovely little rock-bordered pool, using a stream that flows across the adjoining lot. As this fills the pool to overflowing, there has been no necessity for the expensive waterproofing that would have been imperative had the water been obtained on meter from the town supply.

This pool furnishes a point of interest for mothers or nurses with younger children or infants, as well as for older children who may care to get away from the activities of the playground nearer the clinic building. Here, also, is room for croquet, for bowling (that fine old outdoor game), and for basketball practice.

Benches are placed along the sides of this open area and among the trees at the lower end of it. These are for the use of mothers, nurses, and others who may care to sit near the pool.

It has been customary in the

past for the children of the town, and for those who come as summer visitors, to use the little playground alongside the clinic. It is expected, however, that the larger area, with its more generous provisions for play and rest will become even better and more intensively used.

•

The whole lot is being delimited by a fast-growing hedge of native plants. These have done well since being transplanted, and will probably continue so with the help of good soil and sunshine.

By planting native material, which was obtained from the neighboring woods for the mere cost of going after it, effects have been possible that would have proven altogether too costly had the plants been bought in the ordinary way.

A few formal evergreens around the entrances, where the formal touch is considered desirable, were about all that had to be purchased; and these under present conditions were most inexpensive.

The fee of the landscape architect for the whole piece of work was twenty-five dollars. The only other necessary expense was labor, at twenty and twenty-five cents an hour.

Will this small investment pay? I cannot say whether it will or not, in terms of the number of patients attracted to the clinic.

But I do know that it will pay many times over if added pleasure in working, the peace of mind of mothers, and the relaxation and keen enjoyment of the children are the criteria by which "pay" is judged.

After all, efficiency is the test to apply. And any doctor who has tried it knows how much more efficient service he can give when he and his patient are comfortable and at their ease.

In the end, I know that the improvement will "pay for itself" and will leave a bit of "profit" on the side—be it in one form of currency or another!

Literature and Samples »

Editor's Note: These brevities are listed as a service to our readers. It will facilitate the handling of your request, when writing manufacturers, if you will include "ME Item 4-33" as part of the address.

THE BELLEVUE PNEUMOTHORAX APPARATUS receives detailed discussion in a new bulletin offered to physicians by Eimer & Amend, Inc. (ME Item 4-33), Third Ave., 18th to 19th Sts., New York.

•

ARLCO POLLEN EXTRACTS, indicated in the treatment of hay fever, are described in literature offered free to physicians. This material contains illustrations in colors of plants in each doctor's locality. Send requests to the Arlington Chemical Co. (ME Item 4-33), Yonkers, N. Y.

•

THIALION: A booklet bearing this title describes the use of Thialion as an antacid, laxative, and diuretic. Physicians wishing copies may write the Vass Chemical Co., Inc. (ME Item 4-33), Danbury, Conn.

•

FOOD VALUES AT A GLANCE: Here is a revolving chart which shows the acid alkaline reaction, vitamins, mineral value, and amount of protein, fats, and carbohydrates in 80 familiar foods. For a copy, write the Health Products Corporation (ME Item 4-33), 113 N. 13th St., Newark, N. J.

•

DIET SUGGESTIONS FOR CHILDREN AND ADULTS, outlined for postoperative feeding, will be sent on request by the Knox Gelatine Laboratories (ME Item 4-33), 448 Knox Ave., Johnstown, N. Y.

•

SAMPLE BOTTLE OF NICHOLS NASAL OIL, and information about Nichols Nasal Syphon will be forwarded to doctors who write Nichols Nasal Syphon, Inc. (ME Item 4-33), 144 East 34th St., New York.

•

THE VIM-SHEFTEL MICRO-COLORIMETER, for use in blood chemistry, is discussed in detail in a new folder. Physicians wishing a copy may write the MacGregor Instrument Company (ME Item 4-33), Needham, Mass.

SAMPLES OF BAUER & BLACK PROCESSED COTTON, said to set a new standard for absorbency, color, purity, and uniformity, will be supplied to any physician. Apply to Bauer & Black (ME Item 4-33), 2500 South Dearborn St., Chicago, Ill.

•

A TRIAL TIN OF LACTO-DEXTRIN, a product designed to kill putrefactive organisms in the bowel, will be furnished on request. Write the Battle Creek Food Co. (ME Item 4-33), Battle Creek, Mich.

•

CALMOXIDE, described as "a rational pluribase antacid and acid-base balance," receives interesting discussion in a folder which may be secured from the Drug Products Co., Inc. (ME Item 4-33), 26-32 Skillman Ave., Long Island City, N. Y.

•

TWO STEPS FORWARD IN NONSPECIFIC PROTEIN THERAPY: A leaflet bearing this title outlines the principal uses, dosage, and indications for 1. Caseal Calcico (calcium caseinate in colloidal form), and 2. Enagol (silver and calcium casein in colloidal form). For a copy and samples, write the Imperial Drug Corporation (ME Item 4-33), 147 Fourth Ave., New York.

•

SAMPLES OF BILIVAL, a crystalline, molecular combination of sodium cholate and lecithin, will be mailed to physicians who apply to the Ernst Bischoff Co., Inc. (ME Item 4-33), 135 Hudson St., New York.

•

OPERATIONS FOR DETACHMENT OF THE RETINA: Here is a lengthy abstract of a paper read before the Twenty-first Clinical Congress of the American College of Surgeons. It discusses the instruments used, pre-operative preparation, technique, post-operative care, complications, and results. A copy will be sent to any physician by the Post Electric Company, Inc. (ME Item 4-33), 7 East 44th St., New York.

•

THE BARACH-THURSTON SOLARIUM OXYGEN TENT is completely explained in a recent reprint. With it may be obtained an interesting chart showing the various conditions where oxygen therapy is indicated. Address requests to the Oxygen Therapy Service, Inc. (ME Item 4-33), 133 East 58th St., New York.

•

WHY NOT INTESTINAL HYGIENE? A large folder bearing this headline has just been issued for the purpose of intro-

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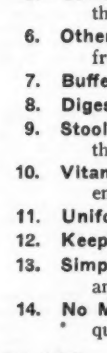

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2-43

ducing Levenol, a yeast culture propagated in an emulsion of oil and agar. Physicians are invited to request copies of this folder from C. E. Jamieson & Company (ME Item 4-33), 1962 Trombly Ave., Detroit, Mich.

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SAMPLES OF PANKOKA, a chocolate-base health food, will be furnished gratis to any practitioner, along with a descriptive booklet. Apply to Pankoka Health Foods, Inc. (ME Item 4-33), 72 Cortlandt St., New York.

•

THE METHOD THAT WILL NOT FAIL: A folder explaining a medical case history and bookkeeping system which has several unique features, is offered by the Medical Case History Bureau (ME Item 4-33), 11 West 42nd St., New York.

•

44 WAYS TO SERVE THE TASTY FRUIT: Here is a small recipe book which explains a number of new ways to prepare cranberries. For a copy, write the American Cranberry Exchange (ME Item 4-33), 90 West Broadway, New York.

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PROCTOLOGIC REQUISITES: This is the title of an attractive, 28-page booklet offered free to members of the medical profession. For a copy, write the Columbus Pharmacal Co. (ME Item 4-33), 330 Oak St., Columbus, Ohio.

•

SAMPLES OF GRAY'S GLYCERINE TONIC COMPOUND AND HYPEROL will be mailed gratis, for clinical tests, to physicians. Write the Purdue Frederick Company (ME Item 4-33), 135 Christopher St., New York.

•

A FREE PACKAGE OF TRENT, the combination dentifrice and mouth wash, will be mailed to any physician by the Trent Laboratories (ME Item 4-33), Lisbon Road and Evins Ave., Cleveland, Ohio.

•

METHYLENE BLUE SOLUTION as an antidote for carbon monoxide and cyanide poisoning is the subject of a new leaflet published by William H. Rorer, Inc. (ME Item 4-33), 265 South Fourth Street, Philadelphia, Pa.

Tours and Cruises »

FOR PHYSICIANS AND PATIENTS

Editor's Note: These brevities are listed as a service to our readers. It will facilitate the handling of your request, when writing companies, if you will include "ME Item 4-33" as part of the address.

GERMANY'S HEALTH SPAS are described and illustrated in several recently issued folders. Reductions are offered to physicians. Write the German Tourist Information Office (ME Item 4-33), 665 Fifth Ave., New York.

●

MOTOR TRIPS IN EUROPE: Here is literature describing a service which, for $8 per person per day, gives the physician a car which he may drive himself, takes care of all operating costs, hotels, and two meals a day. Write Europe on Wheels, Inc. (ME Item 4-33), 218 Madison Ave., New York.

●

INFORMATION ON THE STUDY OF MEDICINE AT ALL EUROPEAN UNIVERSITIES is offered free of charge by the Hamburg-American Line, Educational Division (ME Item 4-33), 39 Broadway, New York.

●

THE ROMANCE OF SCOTLAND: This attractive folder, embellished with numerous photographs and a large map, may be secured by writing the London, Midland & Scottish Railway (ME Item 4-33), 200 Fifth Ave., New York.

●

VACATIONLAND: Each of the principal regions of Maine, with its hotels and available sports, is outlined in this 60-page booklet. Send requests to the Maine Central Railroad (ME Item 4-33), 222 St. John St., Portland, Me.

●

THE MEDITERRANEAN AND NORWAY CRUISE OF THE S.S. VOLENDAM (July 5 to August 28) is discussed in a folder just issued by the Holland-America Line (ME Item 4-33), 21 State St., New York.

●

SAILING SHELTERED SEAS: This elaborate booklet describes in all its details a trip to Alaska. It is supplemented by a wall-size map. For a copy, write the Alaska Steamship Company (ME Item 4-33), Pier 2, Seattle, Wash.

SOVIET RUSSIA: Here is a travel folder containing valuable pointers for the prospective visitor to Russia. For a copy, write to the North German Lloyd (ME Item 4-33), 57 Broadway, New York.

●

AUSTRIA OF TODAY: This sizeable book illustrated in rotogravure constitutes a complete guide to the country. It contains instructive sections on the Austrian medical schools, social insurance, etc. Write for a complimentary copy to the Austrian Tourist Information Office (ME Item 4-33), 500 Fifth Ave., New York.

●

HUNTING AND FISHING IN NOVA SCOTIA: A 36-page booklet published under this title will be mailed free to physicians. Send requests to the Eastern Steamship Lines (ME Item 4-33), Pier 18, North River, New York.

●

YUCATAN, THE LAND OF MYSTERY: The Tiger Temple, the Tomb of Kings, and the House of Dark Writing, are among the many gruesome sights illustrated and discussed in this entertaining travel folder. Write the Munson Steamship Line (ME Item 4-33), 67 Wall Street, New York.

●

NEW ZEALAND TOURS: Physicians planning extended trips this year are offered a new experience in travel on the new liners, Mariposa and Monterey. For copies of literature describing a variety of fully arranged trips at inclusive fares, write the Oceanic Steamship Company, (ME Item 4-33), 215 Market St., San Francisco.

●

GUIDE BOOK FOR YOUR SOUTHERN CALIFORNIA VACATION: Printed in rotogravure, with scores of illustrations, this booklet answers just about every question the prospective visitor to Southern California could ask. Not only does it tell how to get there and what to do and what to see, but it also outlines the essential expenses. Write for a copy to the All-Year Club of Southern California, Ltd. (ME Item 4-33), 1151 South Broadway, Los Angeles.

●

MEDITERRANEAN DE LUXE PASSENGER SERVICE: The ships of this line carry about 125 passengers each. All staterooms are amidships, outside; and all accommodations are first class. For a large, colored, descriptive folder, write the American Export Lines (ME Item 4-33), 25 Broadway, New York.

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Earthquake

(FROM PAGE 23) under control inside of an hour with the help of the Navy and the American Legion. The physicians began to go home not long after that.

All medical needs of the situation were met with a promptness that was breath-taking—a flattering testimonial to the spirit and efficiency of the profession of the present day.

Not only were all needs met, but there was such an overwhelming response from the surrounding territory that before the night had much more than fallen, there were more doctors on hand than patients. Thus, for many, it turned out to be a sight-seeing trip instead of an errand of mercy. A trainload of doctors and nurses, 100 of each, recruited in Los Angeles, reached Long Beach at 10 P. M., only to find themselves superfluous. They returned home without being called upon for any service whatever.

The immediate medical job was chiefly to take care of people who had been struck by falling walls, chimneys, or architectural embellishments, as they rushed to the street. A few victims who had reacted hysterically by jumping out of windows also required attention. Some cases were purely nervous shock.

In Los Angeles, the receiving hospitals and other emergency institutions easily accommodated the rush. Long Beach was the place where greatest difficulty was encountered, for the city has no publicly controlled emergency system. People utilize the nearest hospital or doctor. Since telephone service was cut off, they bundled their injured into autos and transported them as quickly as possible to places where they could receive help.

Long Beach's chief hospitals are the Seaside, Community, and Sisters'. An entire wall of the

McKesson's
ALBOMALT

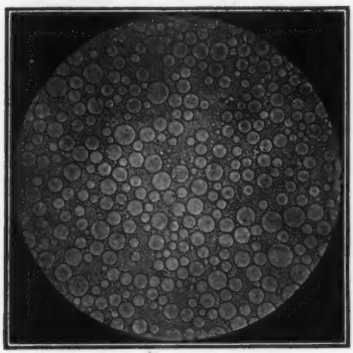

PHOTO-MICROGRAPH OF ALBOMALT

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Constipation usually attendant during pregnancy and period of lactation is corrected by Albomalt in a gentle and effective manner and at the same time provides food factors of known therapeutic value. Bowel action is produced without muscular exhaustion or rectal leakage.

The inclusion of Albolene (Standard for 45 years) which when emulsified breaks the oil into myriads of tiny spheres, vastly increases the lubricating surface and allows free mixture with the chyme.

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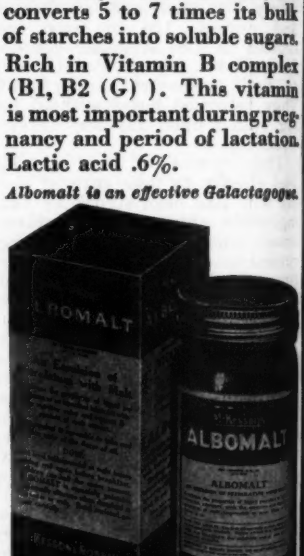


McKESSON & ROBBINS, INC.
NEW YORK, BRIDGEPORT, MONTREAL

Seaside was demolished, laying bare the surgical section. A baby was being delivered and a mastoid operation was in progress in the adjoining room. The mastoid was deferred until the next day.

From all Long Beach hospitals, cases well enough to be treated at home were sent home. Others not very sick were taken out of doors on the lawn. The most serious cases were thus provided ample hospital facilities. Fortunately, the Navy was in the harbor. Inside of an hour they were on hand with stretchers, supplies, and help in profusion. They supplied cots, and erected tents over the exposed ones in short order.

Ambulances from Los Angeles and Pasadena arrived and did their share also. A portable public address system was used to issue general directions from a central point. Order quickly supervened.

The doctors worked under some difficulties, however. At the Seaside Hospital, the first floor was flooded, and the operating suite was exposed to public view by loss of one wall. No running water or gas were available. Regardless of this, the surgeons sewed up wounds and applied splints or dressings with complete nonchalance.

No anaesthetics were given. If anaesthesia was imperative, temporary dressings were applied and further work deferred. Instruments were sterilized by immersion in solutions only.

Good spirits and order soon prevailed.

The Marines, the Navy, and the American Legion threw a net of police protection over the city. No vandalism of any kind occurred.

After real injuries had been attended, the doctors began to be called upon to treat the results of a widespread terror. They are still engaged on these cases. Thousands of people refused to return to their dwellings and spent the night in the parks. These had to be protected from

pneumonia, and calls for tents and blankets went out. Thousands more slept as best they could in their automobiles. Widespread colds resulted. Others lay in their beds wide-eyed, shivering. Sedatives were in big demand the next day.

The public health situation was handled without a single bad feature. Water in San Pedro and Long Beach was considered possibly contaminated for a few days and orders went out for boiling, but safety was quickly re-established.

Old timers contrast the quakes of San Francisco and Santa Barbara with the disaster of last month. In both previous events, lack of communication was responsible for much of the disastrous confusion and disorganization; and lack of transportation was a great hindrance. *This time, is was only a matter of minutes before the whole countryside knew what had happened, where most damage had been done, where help was needed, and what to do about it.*

The Southern California shock is rated as a "moderate" one. The San Francisco shake was probably somewhat more severe, but not a great deal, and the Santa Barbara quiver was little if any more violent. The reason that so much more damage resulted from those previous historic events was that buildings standing at that time were of such construction or condition as to withstand tremors less satisfactorily.

Also, public utility lines were more fragile, with resulting complications from ruptured gas, electric, water, and sewage conduits. The only buildings damaged in the latest of California's headline events were those which were flimsy with age or built of faulty material, or of construction in which brick or blocks were mortared together without reenforcement or binding. Fires were minimal, and all were quenched within a few hours. [TURN THE PAGE]

The problems created by this latest earthquake were greatly reduced by the fact that for a generation California has been earthquake-conscious. Practically all new construction since the San Francisco disaster has taken quakes into consideration. Consequently, explosions, fires, floods, and secondary contributors were almost entirely lacking. Water was not shut off at all in most regions, and only temporarily anywhere. Electricity was back in the wires in from a few minutes to a few hours.

Long Beach's regular radio station went out of order, but all others continued functioning and were kept hot with bulletins as rapidly as the news filtered to them. From the center of the stricken area, information began to emanate quickly as amateur short-wave sets got into connection with those in surrounding regions. In less than an hour everybody in the district knew the whole story.

The bank holiday was forgotten. The only topic of conversation was, and still is, "Where were you when— —?" Many "true experience" stories of a most bizarre nature are forthcoming—some humorous, some serio-comic.

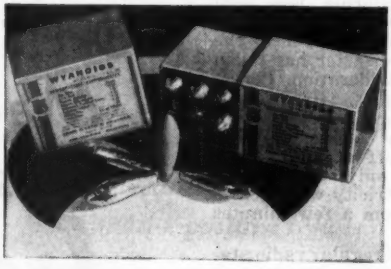
•

One of the most embarrassing predicaments was that of the man who happened to be in his cellar testing home brew. Falling *debris* completely penned him in. Without warning he found himself a prisoner. Unfortunately, he was without light and without much air; since no one knew he was walled in, no one came to rescue him.

All he had to dig his way out with were his fingers. All he had to keep himself alive was his home brew. It took him forty-eight hours to reach the surface.

Once out, he demanded food, ate it, and then rolled blithely over to sleep, mumbling: "Thash good, I'm O.K. now!"

IN HEMORRHOIDS



CONTROL PAIN—RELIEVE CONGESTION WITH

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Wyanoids not only may be used effectively in non-surgical cases, but prior to operative procedure, or subsequently, they are of service in allaying pain, controlling tenesmus and checking inflammation.

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250 Books

[FROM PAGE 21] *Diseases of the Stomach*, 9; Crohn, *Affections of the Stomach*, 8; Spira, *Causation of Chronic Gastro-Duodenal Ulcers*, 7; Kantor, *Treatment of the Common Disorders of Digestion*, 10.

HYGIENE, PREVENTIVE MEDICINE, SEX PROBLEMS, AND SANITATION

Rosenau, *Preventive Medicine and Hygiene*, 1; Park, *Public Health and Hygiene*, 10; Vaughn, *Epidemiology and Public Health*, 6; Boyd, *Preventive Medicine*, 9; Rice, *Conquest of Disease*, 12; Hope, *Industrial Hygiene and Medicine*, 9; Wood, *Sanitation Practically Applied*, 10; Bigelow, *Sex Education*, 10; Popenoe, *Modern Marriage*, 12.

INFECTIOUS DISEASES

Zinsser, *Resistance to Infectious Diseases*, 12; Schamberg and Kolmer, *Acute Infectious Diseases*, Stitt, *Diagnosis and Treatment of Tropical Diseases*, 2; Ker, *Infectious Diseases*, 7; Kolmer, *Infection, Immunity and Biologic Therapy*, 9.

INTERNAL MEDICINE

Osler, *Principles and Practice of Medicine*, 1; Cecil, *Textbook of Medicine*, 8; *Nelson's Loose-Leaf Medicine*, 10; *Oxford Loose-Leaf Medicine*, 10; *Oxford Monographs on Diagnosis and Treatment*, 10; Stevens, *Practice of Medicine*, 8; Musser, *Internal Medicine*, 10; Joslin, *Treatment of Diabetes Mellitus*, 4; Rolleston and McNee, *Diseases of the Liver, Gall Bladder, and Bile Ducts*, 12; Du Bois, *Basal Metabolism in Health and Disease*, 4; Fishberg, *Hypertension and Nephritis*, 4.

MATERIAL MEDICA, PHARMACOLOGY, TOXICOLOGY, PHARMACY, AND THERAPEUTICS

Sollman, *Pharmacology*, 8; Cushny, *Pharmacology and Therapeutics*, 4; Bastedo, *Materia Medica, Pharmacology, Therapeutics, and Prescription Writing*, 10; Arny *Useful Drugs*, 16; *New and Non-official Remedies*, 16; Meyer & Gottlieb, *Experimental Pharmacology as a Basis for Therapeutics*, 10; Underhill, *Toxicology*, 2; Eggleston, *Essentials of Prescription Writing*, 8; Arny, *Principles of Pharmacy* 10; Remington, *Pharmacy*, 10.

NEUROLOGY AND PSYCHIATRY

White, *Outlines of Psychiatry, Introduction to the Study of the Mind, Foundations of Psychiatry*, 15; Jelliffe & White, *Diseases of the Nervous System, Modern Treatment of Nervous and Mental Disorders*, 4; Strecker & Ebaugh, *Practical Clinical Psychiatry for Students and Practitioners*, 2; Henderson & Gillespie, *Psychiatry*, 7; Wechsler, *Clinical Neurology, Neuroses and Psychoneuroses*, 8; Rasmussen, *The Principal Nervous Pathways*, 10; Henry, *Essentials of Psychiatry*, 9; Dana, *Nervous Diseases*, 9; Bleuler, *Psychiatry*, 12; Herrick, *Outlines of Neurology*, 14; Tilney & Riley, *Form and Function of the Nervous System*, 12.

OBSTETRICS AND GYNECOLOGY

De Lee, *Principles and Practice of Obstetrics*, 8; Williams, *Obstetrics*, 1; Graves, *Gynecology*, 8; Crossen, *Diseases of Women*, 10; Curtis, *Obstetrics*, 8.

[TURN THE PAGE]

OPHTHALMOLOGY

May, *Diseases of the Eye*, 9; DeSchweinitz, *Diseases of the Eye*, 8; Parsons, *Ophthalmology*, 12; Rutherford, *The Eye*, 1; Fuchs, *Ophthalmology*, 5; Friedenwald, *Pathology of the Eye*, 12; Moore, *Medical Ophthalmology*.

ORTHOPEDIC SURGERY

Jones & Lovett, *Orthopedic Surgery*, 9; Whitman, *Orthopedic Surgery*, 4; Albee, *Orthopedic and Reconstructive Surgery*, 8; Knagg, *Diseases of the Bone*, 10; Steindler, *Surgery of the Upper Extremities*, 10; Sever, *Orthopedic Surgery*, 12; Campbell, *Orthopedics in Childhood*, 1.

OTOLOGY, RHINOLOGY, AND LARYNGOLOGY

Jackson & Coates, *The Nose, Throat and Ear and Their Diseases; Bronchoscopy and Esophagoscopy*, 8; Politzer, *Diseases of the Ear*, 10; Hollender & Cottle, *Physical Therapy and Diseases of the Eye, Ear, Nose and Throat*, 12; Ballenger, *Diseases of the Nose, Throat, and Ear*, 4; Whiting, *The Modern Mastoid Operation*, 10; Thomson, *Diseases of the Nose and Throat*, 10; Bacon, *Manual of Otology*, 10; Skillern, *Accessory Sinuses of the Nose*, 10; Kerrison, *Diseases of the Ear*, 10.

PATHOLOGY, CLINICAL PATHOLOGY, AND HEMATOLOGY

Boyd, *Pathology of Internal Disease*, 4; MacCallum, *Pathology*, 8; Delafield & Prudden, *Pathology*, 9; Kolmer & Boerner, *Approved Laboratory Technic*, 1; Kaufmann, *Pathology*, 2; Ewing, *Neoplastic Diseases*, 8; Kersner, *Human Pathology*, 10; Hewlett, *Pathological Physiology*, 10; Piney, *Diseases of the Blood*, 10; Gradwohl, *Blood and Urine Chemistry*, 6; Williams, *Natural History of Cancer*, 10; Stout, *Human Cancer*, 12.

PEDIATRICS

Holt and Howland, *Diseases of*

Infancy and Childhood, Clinical Pediatrics, 1; Abt, *Diseases of Children*, 8; Lucas, *Modern Practice of Pediatrics*, 12; Griffith & Mitchell, *Diseases of Infants and Children*, 8; Garrod, *Diseases of Children*, 10; Marriott, *Infant Nutrition*, 6; Hess, *Feeding and Nutritional Disturbances*, 10; Smythe & Jones, *Handbook of Pediatric Procedures*, 12.

PHYSICAL THERAPY AND ELECTROTHERAPY

Stewart, *Physiotherapy*, 13; Kovacs, *Electrotherapy and the Elements of Light Therapy*, 10; Granger, *Physical Therapeutic Technic*, 8; Massey, *Practical Electrotherapeutics and Diathermy*, 12; Thomas and Goldthwait, *Body Mechanics and Health*, 18; Grover, *High-Frequency Practice*, 10; Snow, *Physical Therapy*, 10; Plank, *Actinotherapy*, 10; Jurrell, *Principles of Electrotherapy*, 7.

PHYSIOLOGY

Starling, *Principles of Human Physiology*, 4; Macleod, *Physiology and Biochemistry in Modern Medicine*, 6; Howell, *Physiology*, 8; Bayliss, *Principles of General Physiology*, 10; Wright, *Applied Physiology*, 7; Mathews, *Physiological Chemistry*, 10; Martin & Weymouth, *Elements of Physiology*, 10; Evans, *Recent Advances in Physiology*, 2.

PROCTOLOGY

Yeomans, *Proctology*, 1; Rankin, Bargen, & Buie, *The Colon, Rectum, and Anus*, 8; Mummery, *Diseases of the Rectum, Anus, and Colon*, 10; Pruitt, *Modern Proctology*, 6; Pottenger, *Symptoms of Visceral Disease*, 10; Hill, *Manual of Proctology*, 10.

ROENTGENOLOGY AND RADIOLOGY

Pillsbury, *United States Army X-ray Manual*, 10; McKee, *X-rays and Radium in the Treatment of Diseases of the Skin*, 4; Holmes & Ruggles, *Roentgen In-*

terpretation, 4; Kohler, *Roentgenology*, 10; Kaplan, *Practical Radiation Therapy*, 8; Simpson, *Radium Therapy*, 10; Carman & Miller, *Roentgen Diagnosis of Diseases of the Alimentary Tract*, 8; Robertson, *X-ray and X-ray Apparatus*, 10.

STOMATOLOGY

Mead, *Diseases of the Mouth*, 6; Goadby, *Diseases of the Gums and Oral Mucous Membrane*, 7; Spencer, *Diseases of the Tongue*, 2; Fitzwilliams, *The Tongue and Its Diseases*, 7.

SURGERY (INCLUDING PLASTIC, ORAL, AND INDUSTRIAL)

DaCosta, *Modern Surgery*, 8; Homans, *Textbook of Surgery*, 10; *Nelson's Loose-Leaf Surgery*, 10; Ashhurst, *Surgery*, 4; Babcock, *Textbook of Surgery*, 10; Christopher, *Minor Surgery*, 10; Lewis, *Practice of Surgery*, 10; Mock, *Industrial Medicine and Surgery*, 8; Brophy, *Cleft Lip and Palate*, 2; Hunt, *Plastic Surgery of the Head, Face and Neck*, 4; Brewer, *Surgery*, 10; Lipshutz, *Surgery*, 2; Christie, *Technique and Results of Grafting Skin*, 13; Wakely & Hunter, *Rose & Carless' Manual of Surgery*, 10.

UROLOGY

Young & Davis, *Practice of Urology*, 8; Cabot, *Modern Urology*, 10; Keyes, *Urology*, 1; Chetwood, *Practice of Urology*, 10; Lowsley & Kirwin, *Urology*, 10; Eisendrath, *Urology*, 10; Kelly & Burnham, *Diseases of the Kidneys, Ureters, and Bladder*, 1; Floyd, *Kidney Disease*, 10.

What Publishers Say

[FROM PAGE 18] Let me cite the case of one pre-clinical subject with which I was particularly concerned some years ago. This is a fundamental subject in the medical school curriculum—one in which a textbook is unusually costly to the publisher. One of my books in this field was heartily endorsed by leading teachers in the large majority of medical colleges, but was used as a text by only a few of them. The others, when asked why they did not adopt for their students a book which they liked personally, stated either that they disagreed with the author in a few minor matters, or that they felt the book made the subject too easy for the student!

The discarding of a good book for such non-essential reasons brings about not only the restricted publication of other volumes in this line, but also the curtailment of the writings of real teachers, badly needed by students.

The crux of the medical school's attitude toward books can be summed up in a remark made not long ago by a prominent teacher: "There are no adequate textbooks ever published." This man's lack of understanding seems lamentable to me. Yet I know that it is not at all uncommon.

The two questions I ask my-

self when reading a medical book manuscript are:

1. Does this book add to medical knowledge? (In other words, is it padded, or is it a "rehash"?)
2. Will it sell?

That it meets the second requirement is not enough. The reader, in my opinion, should benefit equally with the publisher. If he does not, the book will later reflect on the publisher. *Books should not be sold by the pound.* Publishers who observe this principle can still make money and know that they are conducting their business in an ethical fashion.

The relationship between publisher and author which once existed should again be brought into effect so that the former will at all times be a literary advisor and adjunct to the latter.

Following a policy of this sort may require many years to build a list of good titles; but over an extended period the publisher will benefit more fully than he ever could otherwise.

Today, there are probably about 10,000 practicing doctors in this country who can be called habitual buyers of general medical books. Among specialists the number of potential buyers is even more limited.

We are finding it to be true that really worthwhile medical books, at moderate prices, can be sold even in a time of major economic depression. It is encouraging to observe, moreover, that an ever increasing number of medical practitioners are in agreement with our point of view, as evidenced by their correspondence with us, and by such public statements as that by Dr. Rowell.

•

Comments by Edward T. Speakman, president, Chicago Medical Book Company:

THERE should be at least twenty volumes in the library

1892

THE TEST OF TIME

1932

GRAY'S GLYCERIN TONIC COMPOUND

(FORMULA DR. JOHN P. GRAY)

We now, after 40 years experience, even *more confidently* suggest its use in the present-day conditions complicated by influenza, common colds and allied ills. Will you test it, as thousands of *critical* physicians have done through this long period of years?

Samples are sent only to the medical profession.

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135 Christopher St. New York, N. Y.

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A UTERO-OVARIAN TONIC AND CORRECTIVE

HAYDEN'S
VIBURNUM COMPOUND

THE physician with a large practice never forgets that the comfort of the patient is an essential part of the art of healing. To win the confidence and gratitude of the patient by prompt relief, many doctors rely on a safe, effective antispasmodic and sedative such as HVC (Hayden's Viburnum Compound).

This product is indicated not only in general medicine but also in obstetrical and gynecological practice. It contains viburnum opulus, dioscorea villosa, and aromatics, but no narcotics, and has no unpleasant after effects.

For free sample, to members of the profession, tear out this advertisement, write your name and address clearly in the margin, and mail to

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of a general practitioner starting practice in 1933, but we doubt if this level is often reached, especially in these strenuous times. The average general practitioner's library, consisting of books carried over from his school days and new books purchased from time to time, would possibly average one hundred to one hundred and fifty volumes, while a specialist's library would probably range around fifty. The great majority of books in each of these libraries are purchased after entering practice, as possibly only eight or ten college books would be suitable to carry over.

We have found, after some thirty years contact with the student body and medical profession, that those who buy medical books and keep up to date through their use, are by far the more successful practitioners. We have seen students who manifested a love of books from their freshman year through graduation, who were constantly in our store browsing around and looking over the new books, and who, in after years, are now noticed to be going right to the top—without any undue delay.

•

Comments by Ralph Steffens, editor, Medical Department, D. Appleton and Company:

I THINK Dr. Rowell's argument that *medical books should be published down to a price* is untenable. Medical books, like fine automobiles, are meant for the consumption of a certain select class of individuals.

The margin or profit on a medical book is obviously not large. To reduce the price of a book from, say, ten dollars to nine dollars would probably wipe out most of the publisher's profit. And would it sell more books? I don't think so. Does the wealthy man contemplating the purchase of a fine car decline to consider a Cadillac because the price is $4,000 instead of $3,900?

Dr. Rowell says that able clinicians largely withhold their genius from medical literature. Consider Kelly, Keyes, McCrae, Kolmer, Yeomans, Shamberg, Williams, Kosmak, Thompson, and other outstanding men. It would be idle to deny that their works in medical literature are anything but excellent.

For the allegation that such men are difficult of understanding, I see no basis. Naturally medical literature is not comparable to the literature of other arts and some other sciences. The doctor wants information that will help him cure Mary's pimples and Johnny's stomach ache. If he wants recreational literature, there's plenty of that available.

The gist of Dr. Rowell's complaint seems to be "why aren't doctors buying more medical books?" If he is speaking of present times, one might also ask, "why aren't farmers buying more automobiles?" They haven't the money, that's why.

[More comments by publishers next month.—ED.]

Marion Plan

[FROM PAGE 75] is also the sum of from $100 to $150, which is left in the treasury for miscellaneous expenses of the society. The balance is then pro-rated among the members in proportion to the amount of services rendered by each.

All physicians eligible to participate in the plan are members of our county society, with a few exceptions. These are practitioners from neighboring counties who are often the most quickly available for cases near our county border. The bills of these non-members are treated in the same way as those of regular members.

A trained social worker is a valuable adjunct to the successful fulfillment of a county contract. Her office serves as a general clearing house for all indigent cases.

●

In drawing up a contract, great pains must be taken. It is imperative that the contract be inclusive as well as exclusive and specific. Our contract reads as follows:

> The Marion County Medical Society hereby agrees to render to the pauper poor of Marion County, as the same are defined in Section 6297 of the Code, including inmates of the County Farm, and excluding persons confined in the County Jail, ordinary medical and surgical care, not including, however, major, surgical or other unusual special work for which other provisions are made by law for the poor of the County, and State, and not including ambulance services, or the use of diphtheria anti-toxin or insulin treatment for diabetes, or the administering of other unusual serums, anti-toxins, and the like, for a period of one year from the date hereof.

Perhaps the greatest task in the whole proposition is the annual auditing of claims. To simplify matters, a code of rules was adopted by the society. They provide as follows:

1. A statement of account shall be made, charges shall be itemized, each item shall be complete.
2. A social worker or township

trustee shall endorse each bill as made.

3. The nearest physician shall attend the case. If another physician attends, his charges shall be the same as those the physician nearest would impose.

4. No consultation with a physician outside Marion County shall be paid from this fund.

5. Anti-toxins and serums shall not be paid for from this fund.

6. When bills for any case are getting large, it is suggested that the attending physician consult with the auditing committee so that a better understanding may be had when the bill comes up for final disposition at the end of the year.

7. All bills not filed with the secretary at the end of the current year shall be cut fifty per cent.

8. All bills shall be made out on uniform county claim blanks.

9. No bill for an individual case shall exceed the sum of one hundred dollars in any given year.

In January, 1931, the Supreme Court of Iowa rendered a decision that a corporation cannot practice a learned profession. To overcome this legal complication, we employed an attorney to work out a new plan for us. This we have named the "Group and Agent Plan."

In brief, this is the general way it works:

Instead of acting nominally as a county society, we act as a group of individual physicians. We appoint and authorize one of the group as agent to submit our bid, to execute the contract, to collect, to receive, and to receipt for the amounts payable under the contract.

Our agent endorses over to the treasurer of the society such funds received, whence they go into the treasury to be disposed of later.

Under this new arrangement, practically all our members have malpractice insurance. Thus, the question of individual liability is not the snag it might otherwise be.

•

Our county board, members of the medical profession, and even the indigents themselves, are well pleased with the practical application of the Marion County Plan.

"On the Brush -- a Dentifrice In Solution -- a Mouthwash"

The Sodium Perborate content is reinforced and activated by Ortho-Iodo-Benzoic acid, which is why TRENT is preferred to preparations of straight Sodium Perborate.

If you are not yet acquainted with TRENT, let us send you samples or enclose 25c stamps or coin for regular 75c, 4 ounce bottle for *personal* use.

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Lisbon Road and Evins Avenue, Cleveland, Ohio

Photography

[FROM PAGE 37] pense is of no great importance, and the camera is to be used continuously in his profession, the physician may purchase either a *Scientific Graflex* with the tripod and lighting equipment described in the preceding pages), or the *Eastman Clinical Camera Outfit.*

The *Scientific Graflex* makes it possible to expose the negative within the same second it is brought into focus. This is a decided advantage when taking pictures of children and nervous adults. However, such a camera with equipment runs over the hundred-dollar mark. Another drawback is its size; for it becomes quite heavy when carried any distance.

The *Eastman Clinical Camera Outfit* is ideal for biological and medical photography, and should be purchased when there is a continuous and considerable amount of work to be done. It is an outfit designed for a definite purpose, so the physician should not expect to use it for his outdoor trips.

Those who care to read further on the subject of making clinical photographs may consult the following articles and publications:

CLINICAL PHOTOGRAPHY, a booklet published by the Eastman Kodak Co.

CLINICAL PHOTOGRAPHY BY THE PHOTOFLASH LAMP METHOD. Fuchs, Arthur W., Journal of the Biological Photographic Association, September, 1932, page 34.

TWO CAMERAS HELP ME TELL THE PATIENT. Sherwood, K. K., MEDICAL ECONOMICS, December, 1932, page 30.

MEDICAL PHOTOGRAPHIC ILLUSTRATIONS. Radiography and Clinical Photography, December, 1932, page 18.

FLASHLIGHT PHOTOGRAPHY. Radiography and Clinical Photography, May-June, 1932, page 14.

REQUIREMENTS FOR CLINICAL PHOTOGRAPHY. Radiography and Clinical Photography, August, 1931, page 14.

Medical Books

(FROM PAGE 16) though some of the more remote diseases are, of what use is material on them to the busy medical man? The general practitioner has neither the time nor the equipment for following obscure trails. For such was the specialist created. Why should he have to pay for what he is not going to use?

I have in my own library a little book on *Principles of Medical Treatment* by George Cheever Shattack; a small *Applied Anatomy*, by Sir Frederick Treves; a *Laboratory Manual* by Wheeler and Hunter; and others. Each of these rings the bell adequately, and at a cost of not over three dollars.

I will admit that it takes extraordinary diplomacy to ap-

...ach an eminent clinician or ...search scientist and demand ...t he cut in half his thousand-...ge, typed manuscript throw ...way much of the art work, and ...ossibly obtain a collaborator ...ho can write (a point to be ...mplified presently).

No doubt, if this were done, the ...ook would never appear. If it ...id appear, condensed, it would ...t be that man's monument in ...e sense of containing all that ...e thought should appear under ...is name.

But supposing this book were ...t, would the world cease to ...ove? Every other publisher's ...t has one sufficiently good to ...ve the subject from oblivion.

•

From a literary point of view, ...any medical books are extreme-...y weak. Organization, termin-...gy, and clarity do not measure ...p to professional writing stand-...ds. Medical authors, and their ...blishers as well, seem to for-...t that writing is a trade, a mat-...r of making words express ...oughts—always with unmistak-...le clarity.

The prominent clinician is not, ...y virtue of his prominence, a ...riter—nor even a competent ...dge of book material. I still ...ve vivid recollections of trying, ...medical school, to interpret ...xts which were difficult enough ...understand, even with the aid ...a medical dictionary. I could ...ve done almost as well had they ...en in French or German.

I have since come to realize ...at the reason why the subject ...atter was not clear to me in ...any texts was that *the author ...d not made it clear.* Hence, ...now wonder *if it was clear in ...e author's own mind.*

True, Osler was a great writer. ...d if you read John Lovett ...rse's *Clinical Pediatrics,* It ...as if you were actually listen-...g to him at his clinics. The ...eat medical writer gives you ...mething of himself, something ...t obtained in the customary re-

view of past literature, which is the basis of most tomes written in these days.

Many of the most able physicians are not making their rightful contribution to medical literature. In all likelihood, they realize the terrific punishment involved in writing really good stuff. John T. Flynn, popular author of articles on finance, writes no less than six drafts of a single article. The labors over manuscript of the brilliant Clarence Buddington Kelland are proverbial. Books require even more time, patience, and experience, plus any erudition and native genius the author can blend into them.

It is a pity that many able clinicians who have much to give are not, on more occasions, linked with well-trained and sympathetic Boswells who can put their ideas in acceptable form. What books would result!

A criticism in the same category with faulty writing, is that many medical books are too technical. A number of the books and papers I read remind me of a certain boy with an I. Q. of 180 (which is about as high as they come) whom my good psychologist-friend, Dr. Leta Hollingworth, was demonstrating to her class in my presence. After hearing that boy talk, Noah Webster himself would have felt ashamed of his vocabulary.

If general practitioners must read as they run—and most of them do—then "a pain in the joint" had better be just that and not "arthrodynia," even if scholarliness is sacrificed. After all, a reader ought to understand his book without a chart. Or else publishers will have to sell together the book and its literal translation into English, after the manner of the "trots" we used in our Latin and Greek courses.

Now for a constructive suggestion. There has been, of late, an interesting trend in books used in professional schools as well as in those intended for children in classrooms. This trend has been toward what we might term "humanization," meaning that the material is presented in terms of human life and experience, and is expected thereby to become of immediate practical value to the reader. *Education today is teaching the individual to live.* Can we transfer this idea to doctors and doctoring?

Case study material would seem to represent "humanization" as applied to the general practitioner. Yet cases, quite often, are selected in the interests of the writer, not of the reader.

If the general practitioner is the great practical psychologist which I believe him to be, then he will have to be given literature which considers man not as a dissection, but as a creature with feelings. Moreover, it will have to shed its present stiff and unyielding style, and come down to earth. (TURN THE PAGE)

I don't want to seem overcritical about the publishers. I have editors who help me mightily in my own bookish endeavors. Publishers, I'll grant, have to be conservative. They can probably tell you, within a hundred, just how many copies of your masterpiece will sell in a year. They make money on their present methods. Who shall quarrel with a meal ticket, especially these days?

But looking at the matter in a far-sighted way, I believe that physicians are paying unnecessarily high prices for medical literature published on a formula that is thoroughly antiquated, extravagant, and ineffective.

Keen's *Surgery* stood up for years, and lawyers based their cross examinations on it. Osler's *Modern Medicine* was magnificent, too. *But what are the Oxford, Nelson, and Tice loose-leaf series today but confessions that material may be stale almost before you get it in print?*

In my opinion, therefore, the need for cheaper books, revised more often, is inescapable. That sums up Criticism No. 1.

Professor Bagley, a colleague of mine who is now famous, has taken a great deal of interest in what is referred to as "the professional treatment of subject matter." Basically, in terms of the general practitioner and his literature, this means presentation of the material in a manner which will enable the professional man to make the most practical use of it.

What we need are books that deal with the common things in medicine, books that deal with them soundly, adequately, and in such a way as to give the general practitioner, clearly and concisely, the latest available information, or, rather, the latest *usable* information about each field.

Insulin, for example, was principally an interesting discovery until it was given to the general practitioner with a satisfactory

technique of administration, described in detail.

Criticism No. 2 is, therefore, that medical books are generally too academic, even for semi-academicians like physicians.

•

So much for books. Now for a word or two about the professional journals. First of all, they are too numerous. Circulation for most of them is bound to be small. Hence, the overhead makes costs prohibitive.

Judging from the contents of these journals, there is not enough first class material to go around. I am thoroughly in sympathy with medical men who write only when they are adding something to a subject.

It is my hope that from this article certain constructive suggestions may help bring about a newer and better state of affairs, with the result that *more* doctors will read *more* books.

My most important query, accordingly, is this: What doctor exists who would not, if able, buy literature which he believes will help him in his work? Indeed, may not the practitioner now have one hand in his pocketbook ready to purchase something which is not available? Is his apparent literary banquet more than a Barmecide feast? May it not be that he is asking for a substantial sandwich and is compelled to buy a nine course dinner, much of which is superfluous and indigestible?

We may take a lesson from the teaching profession, which puts out books for its members, at one, two, or three dollars a copy, and magazines at similar prices. These are read by teachers who must either keep up-to-date or find themselves on the scrap heap. Comparisons are always odious, but this paragraph is not intended as a *comparison*.

It's the proof of the pudding

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